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Overview

This report summarizes Task 1 of the National Institute of Mental Health-funded project: “Engaging large employers regarding evidence-based behavioral health treatment.” Task 1 is comprised of two components: a survey of large employers (Task 1.1) and structured industry stakeholder interviews (Task 1.2). Each component served to obtain a better understanding of large employers’ current offerings of behavioral health benefits. The survey also explored recent benefit changes and the processes used to implement those changes, while the interviews provided deeper insight into consultant and industry partner recommendations to employers. Findings from this study are helping guide the National Business Group on Health in developing an employer toolkit for implementing behavioral health benefits.

1.1 Employer Survey on Behavioral Health Strategies and Productivity

The survey of 106 large employers identified several key findings on how employers view behavioral health and what types of programs they have in place to address behavioral health problems of employees and beneficiaries. Specifically:

- Despite collecting and integrating data on behavioral health, employers appear to have little understanding of how behavioral health affects different types of business costs, especially productivity, absenteeism, and employee turnover.
- Employers rely heavily on consultants and industry partners as sources of information in determining behavioral health benefits.
- Only 68% of respondents reported having a protocol in place for screening for co-morbid mental illness. Of those, 56% had a referral process in place when employees screen positive.
- Employers also appear to place few requirements on their health plan administrators, disability carriers or behavioral-based programs such as EAP to ensure best practices in regards to care provided or coordination of care.

1.2 Industry Interviews with Leading Stakeholders

Since employers rely heavily on consultants and industry partners as sources of information in determining behavioral health benefits and services, interviews with 17 industry stakeholders were conducted to gain further insight into what employers are asking of their industry specialists and consultants. Results of the interviews represent the types of recommendations and resources that stakeholders are providing to employers.

Several consultants felt that while some employers are making benefits changes to comply with parity legislation, overall ***many do not invest enough in behavioral health and do not understand the true impact of behavioral health issues on the workforce and overall company.*** A theme repeated throughout the interviews addressed the issues of data integration. Many stakeholders, including managed behavioral health organizations (MBHOs), spoke about their efforts to integrate their data with medical and pharmacy, as well as with those collected by disability and employee assistance programs

(EAP) providers. Furthermore, pharmacy benefits managers feel that they will be able to work with disease management companies to identify patients who fill psychotropic prescriptions. The PBMs already employ similar processes to identify diabetes and cardiovascular patients for the disease management program.

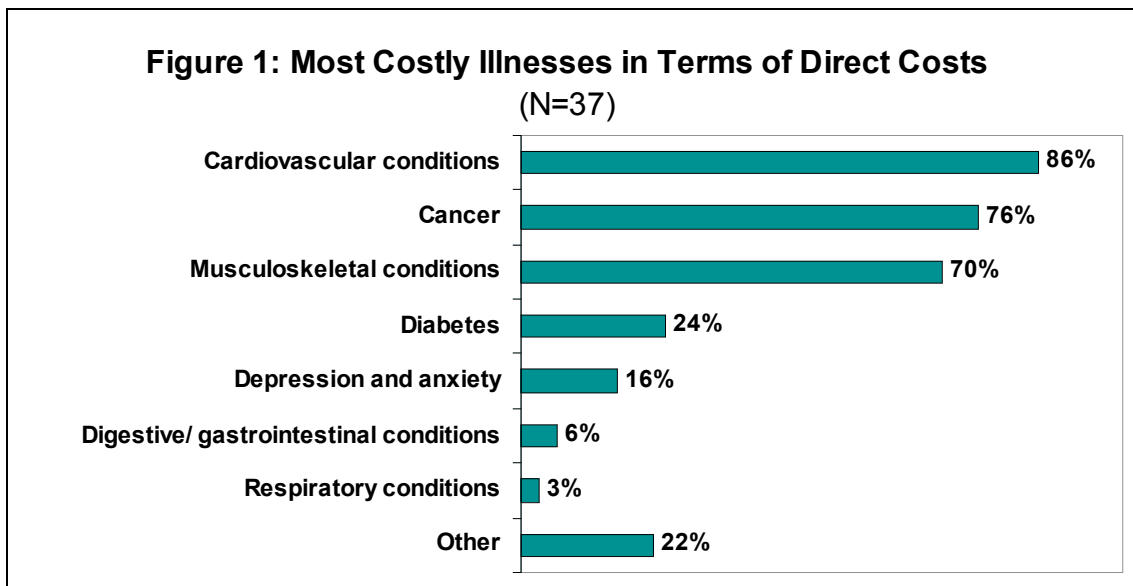
The remainder of this report provides a detailed review of the findings from each task, as well as provides a conclusion regarding the current state of employer behavioral health benefits.

Task 1.1: Employer Survey on Behavioral Health Strategies and Productivity

This section summarizes findings from the National Business Group on Health’s Employer Survey on Behavioral Health Strategies and Productivity. The purpose of this survey was to obtain a better understanding of large employers’ current offerings of behavioral health benefits as well as recent benefit changes and the processes used to implement those changes. An online version of the survey was launched in September 2008, and follow-up phone calls using an abridged version of the survey began in November 2008. Due to the economic downturn and immediate need of our employer members to focus on large issues such as workforce reductions, the number of respondents was lower than expected. Overall, there were 106 participants in this survey, with 37 completing the full survey and 69 completing the abridged version. Appendix A contains the names of the 61 companies who agreed to be listed as a participant in this survey.

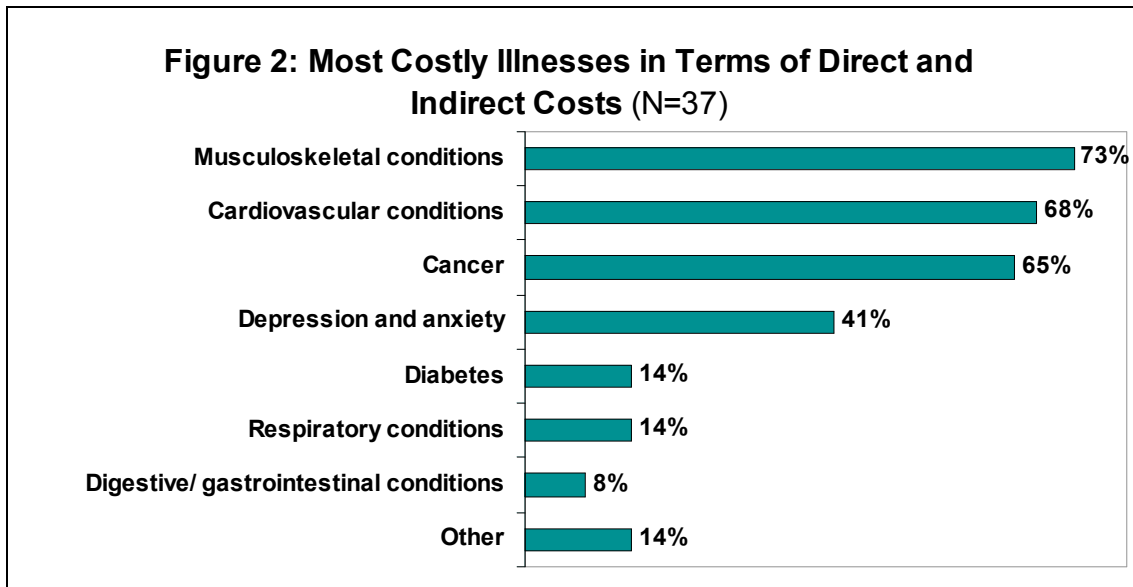
Burden of Illness

Respondents were asked to answer a series of questions regarding their perceptions of what are the most costly illness among their employee population. When asked to identify the three most costly illnesses in terms of direct health plan costs (i.e. costs directly associated with general medical, specialty behavioral health and pharmacy), the majority indicated cardiovascular conditions (86%), cancer (76%), and musculoskeletal conditions (70%). Only 16% of respondents reported depression and anxiety as one of the top three costly conditions.



Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 6 reported maternity-related conditions, and 1 respondent said congenital and hereditary disorders.

By comparison, when asked to consider indirect costs (i.e. lost productivity, absenteeism, long-term and short-term disability costs, and employee turnover) along with direct costs as to what they perceive to be the 3 most costly health conditions, cardiovascular conditions (68%), cancer (65%), and musculoskeletal conditions (73%) were still the top three conditions reported, but depression and anxiety was now reported by 41% (Figure 2), indicating that some employer understood the far-reaching impact of behavioral health problems.

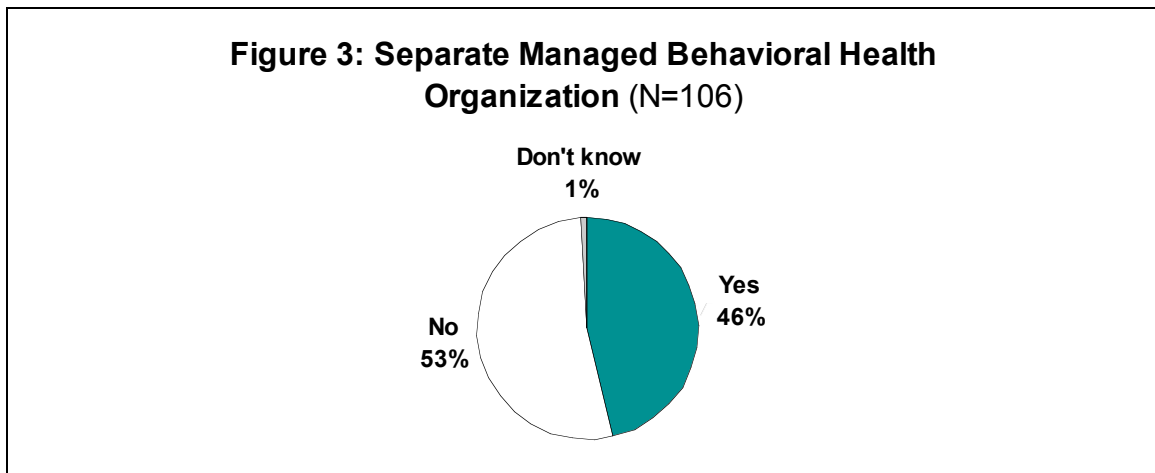


Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 3 reported maternity-related conditions, 1 respondent said obesity, and 1 did not know.

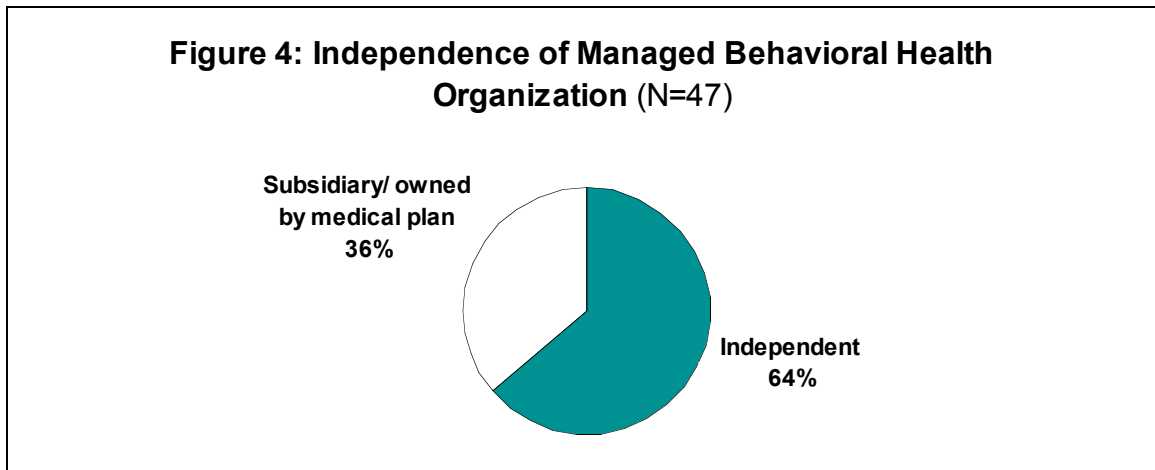
Managed Behavioral Health Organization

In an effort to better understand how employers administer behavioral health benefits, employers were asked several questions relating to managed behavioral health organizations (MBHO). These questions were included to understand who was carving-in the benefits as opposed to carving out to a separate managed behavioral health organization. The type of relationship an employer has can play a role in how well they are able to track their direct costs associated with behavioral health but also their ability to integrate their data with other sources to get a better picture of the impact of behavioral health disorders on their population and company.

Figure 3 shows that of the 106 companies that responded to the question, 46% of the companies contracted with a separate managed behavioral health organization, and 53% of the companies did not.

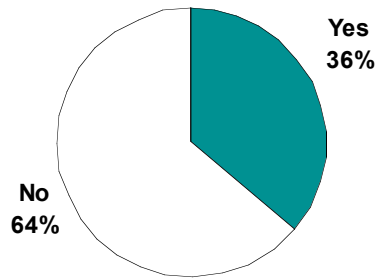


Of those companies who carved-out the benefit, 64% reported that the managed behavioral health organization was independent of their medical plans (Figure 4). Alternatively, 36% of the managed behavioral health organizations used by companies were a subsidiary or owned by one of the medical plans they were using.



For those employers who carved-in their mental health benefits, they were asked if they received data and/or reports on specialty behavioral health costs separate from their general medical plan costs. The majority indicated they did not receive a separate report. Only thirty-six percent of employers reported that they did receive separate behavioral specific data and/or reports (Figure 5).

Figure 5: Receive Separate Specialty Behavioral Health Costs Data (N=58)



Data Collection

In an effort to better understand what kind of information employers use in their decision making, employers were asked a series of questions that focus on the data they receive.

When asked if they collect data on what proportion of various costs are due to behavioral health disorders, employers cited that they most frequently collected the data for (Table 1): pharmacy costs (65%), general medical plan costs (58%), short-term disability costs (32%), and long-term disability costs (29%).

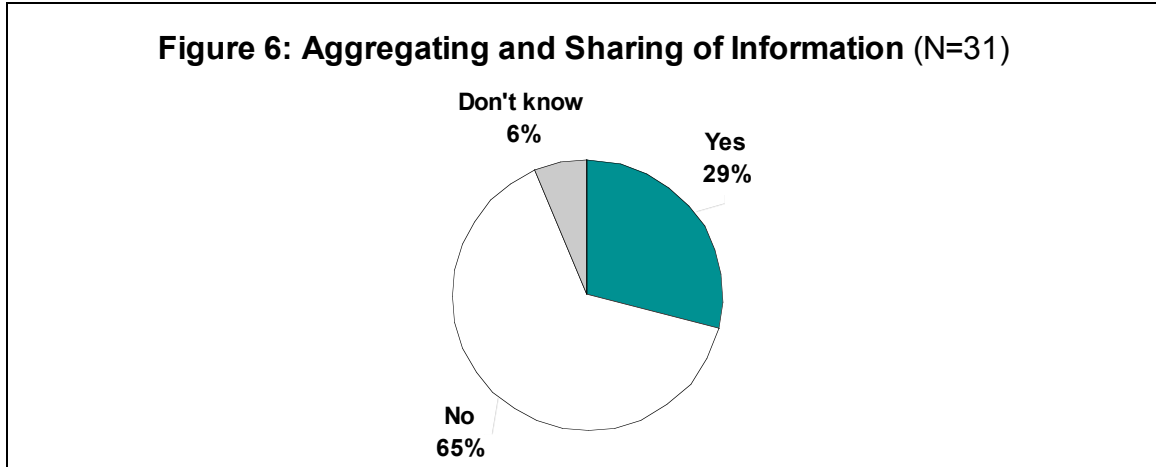
Table 1: Data Collection Due to Behavioral Health Disorders (N=58)

| Types of Data | Percentage of Employers |
|---|-------------------------|
| Pharmacy costs | 65% |
| General medical plan costs (Separate from specialty behavioral costs) | 58 |
| Short-term disability costs | 32 |
| Long-term disability costs | 29 |
| Family Medical Leave | 16 |
| Worker’s compensation program costs | 10 |
| Productivity* | 6 |
| Incidental absence/absenteeism | 3 |
| Other | 23 |

Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 2 companies reported collecting data specific to diagnosis only.

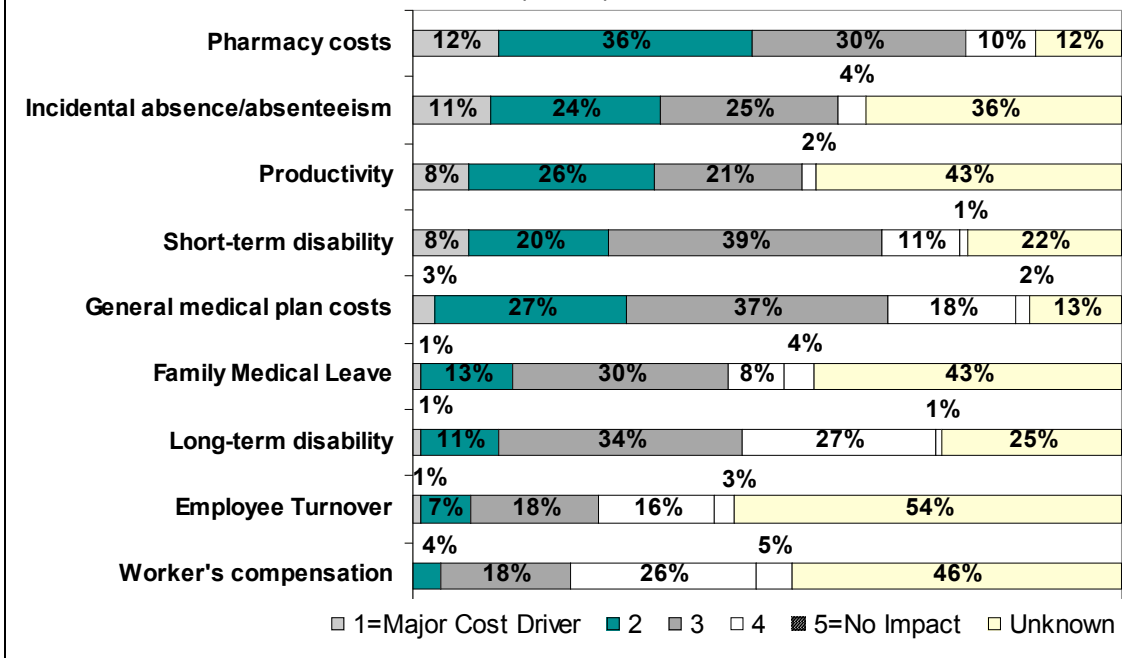
*The Institute on Health, Productivity and Human Capital of the National Business Group on Health defines productivity as the total workforce’s quantitative and qualitative output, February 2009.

When asked if the behavioral health information that is collected is aggregated and shared with the medical plan, PBM, and managed behavioral health organization, 65% of the employers responded that it was not aggregated or shared. Only 29% of employers did share the information to facilitate tracking and monitoring of patients with behavioral health problems (Figure 6).



One of the key questions posed to respondents addressed their awareness of how behavioral health problems impact various types of costs. Although many of respondents believed they knew the impact of behavioral health programs on pharmacy costs and general medical plan costs, more than half (54%) of respondents did not know how behavioral health impacted employee turnover (Figure 7).

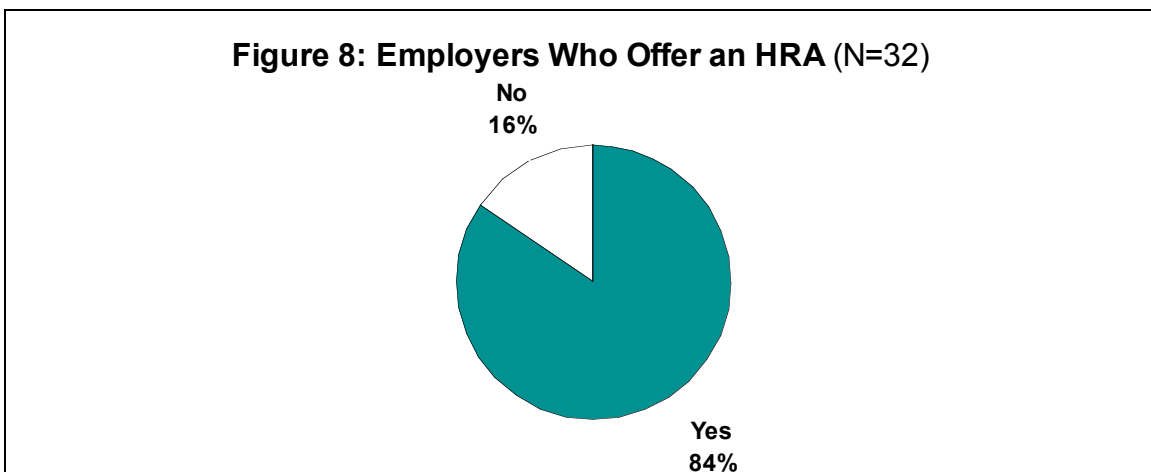
Figure 7: Behavioral Health Problems as a Driver of Cost
(N=93)



Health Risk Assessments

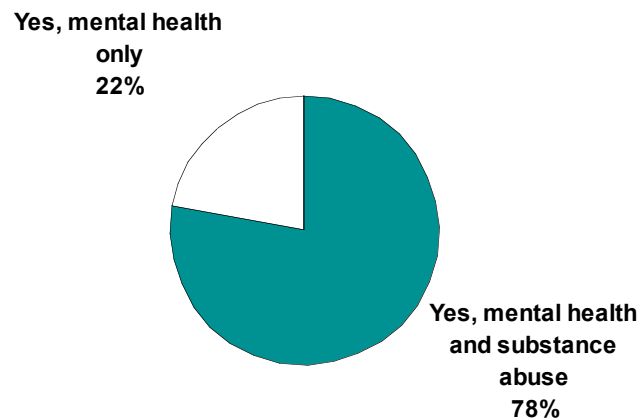
Respondents were asked a series of questions to understand if they use their health risk assessments (HRAs) to identify and assist employees with behavioral health risks and disorders. Of those 32 employers who responded to the question, 84% of employers offered an HRA to their employees (Figure 8).

Figure 8: Employers Who Offer an HRA (N=32)



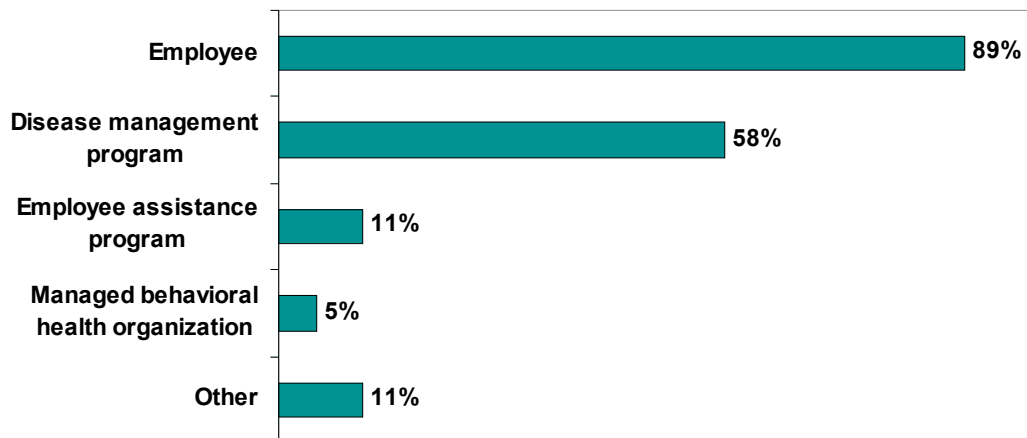
To better understand what behavioral health information employers were obtaining from their health risk assessments, respondents were asked whether their HRA contained questions regarding either mental health or substance use/abuse. All employers reported including questions on mental health, and 78% also included questions about substance use/abuse (Figure 9).

Figure 9: HRA Containing Mental Health and Substance Use/Abuse Questions (N=27)



Employers were asked with whom they share the information they obtain from the HRA. While 89% of employers reported sharing that information with their employees, 52% shared the information with the disease management program being used (Figure 10).

Figure 10: Sharing of HRA Information (N=19)



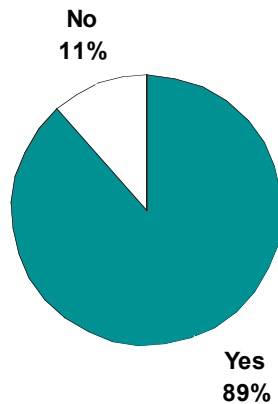
Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 1 company reported sharing the information with an employee’s personal health coach, and 1 said it varied by health plan.

Disease Management Programs

Respondents were asked a series of questions relating to the types of disease management programs they offer and the process they have in place to identify employees with co-morbid depression or other mental illnesses. Overall, 89% of the respondents offered a disease management program (Figure 11).

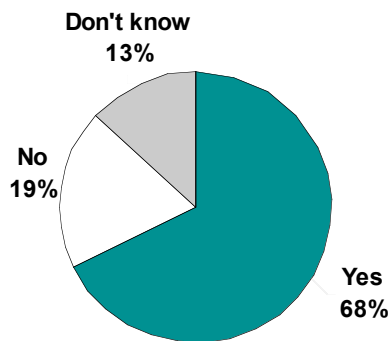
Figure 11: Offering of Disease Management Programs

(N=97)

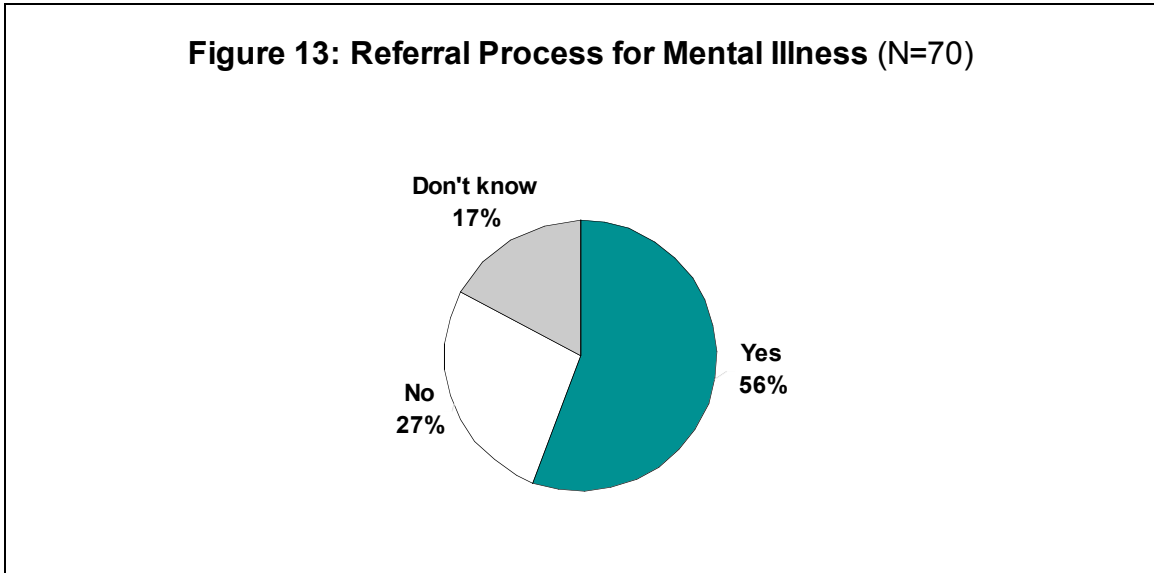


For those that offered a disease management program, 68% had a protocol in place for screening of co-morbid illness (Figure 12). In contrast, 19% of employers did not have a protocol in place and 13% did not know.

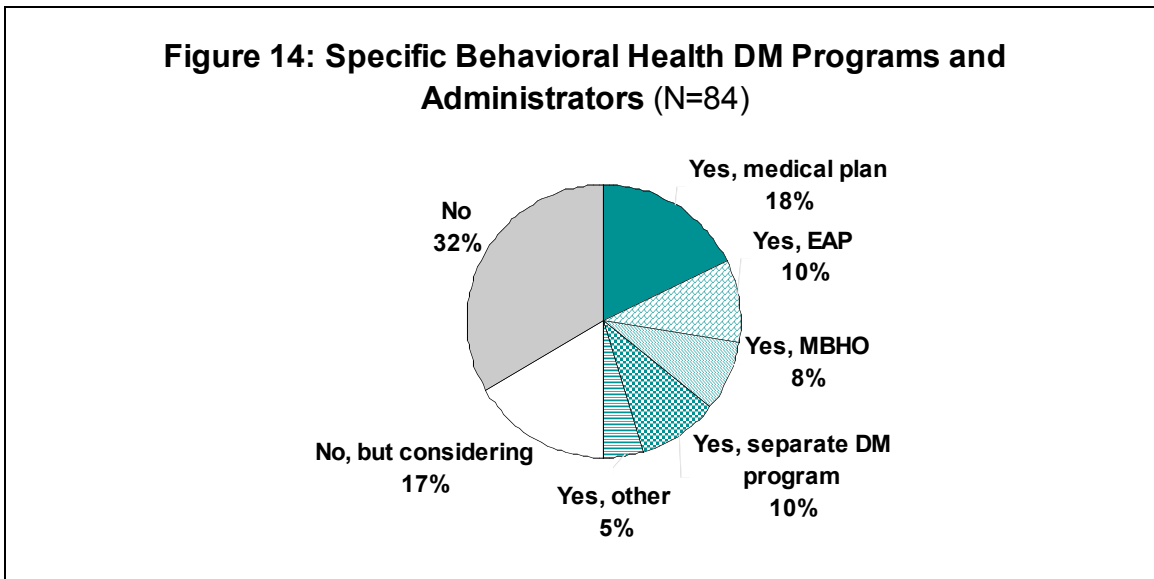
Figure 12: Protocol for Screening for Co-morbid Mental Illness (N=84)



However, despite 68% of employers reported having a protocol in place to screen for co-morbid illness, only 56% had a structured referral process in place for those employees who screen positive for a mental illness. 27% did not have any process in place (Figure 13).



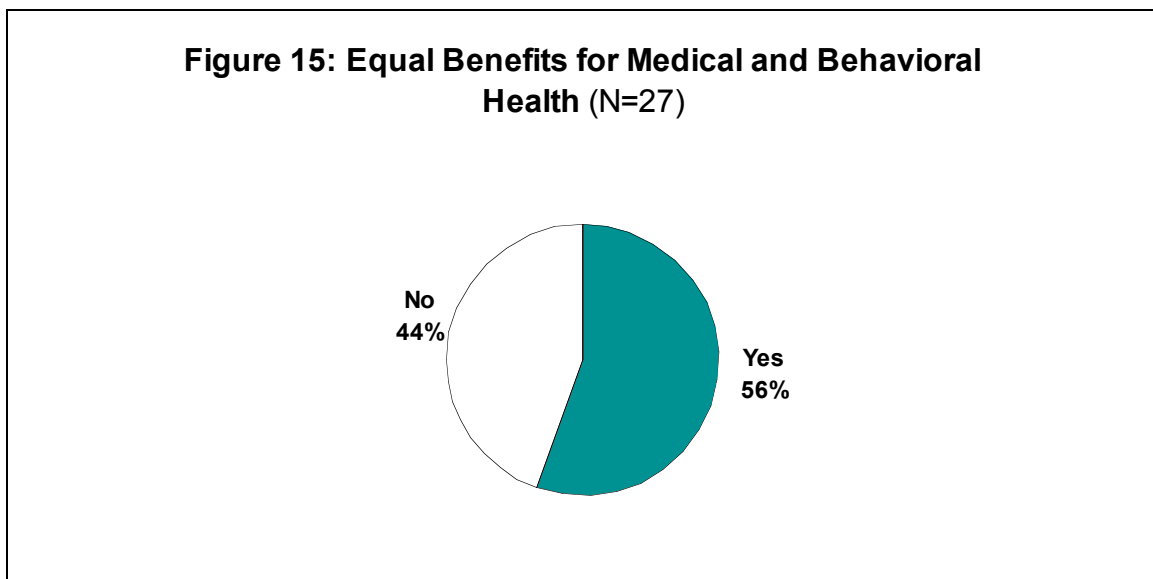
Employers were asked if they offered any disease management program specific to behavioral health problems. Half of the employers who responded to the question offered specific behavioral health programs. The other half of employers did not offer behavioral health specific programs, but 17% were considering doing so in the future (Figure 14).



Behavioral Health Benefits/ Work Productivity Strategies

When asked if employers currently offer equal benefits for medical and behavioral health (i.e. similar treatment limits, equal cost sharing), 56% of employers responded that they

did (Figure 15). This finding will likely change as a result of the passage of the **Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008**, which goes into effect January 1, 2010.



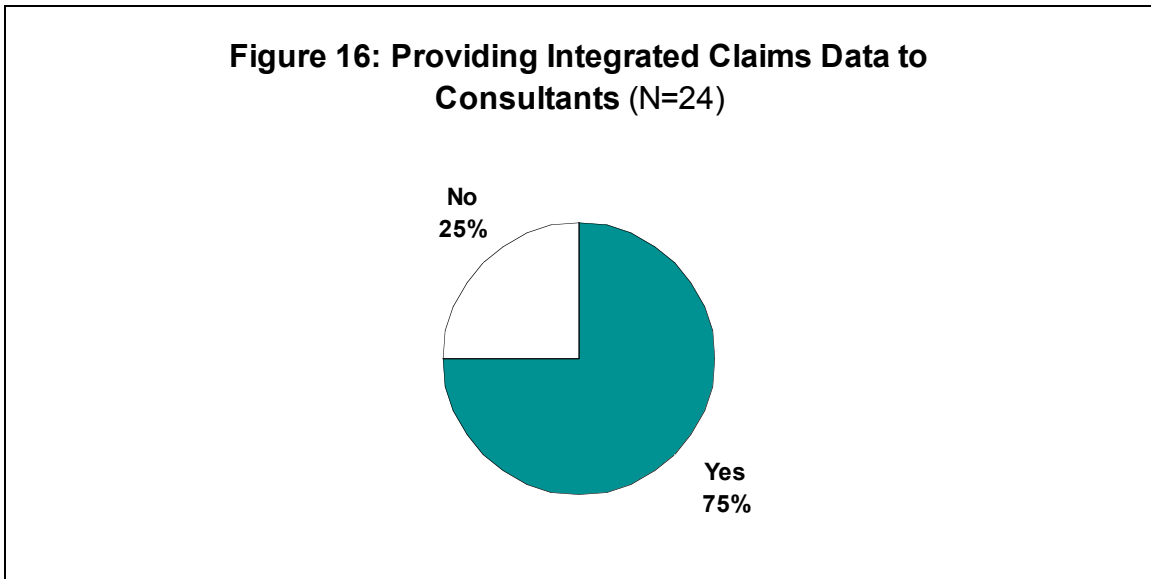
When asked to rank the importance of various types of information as they relate to determining behavioral health benefits (on a scale of 1 to 13; 1 being the most important), employers reported that recommendations by consultants are the most important, followed by recommendations by industry partners and benchmark reports, such as EMPAQ (Table 2).

Table 2: Ranking of Value of Information Sources (N=25)

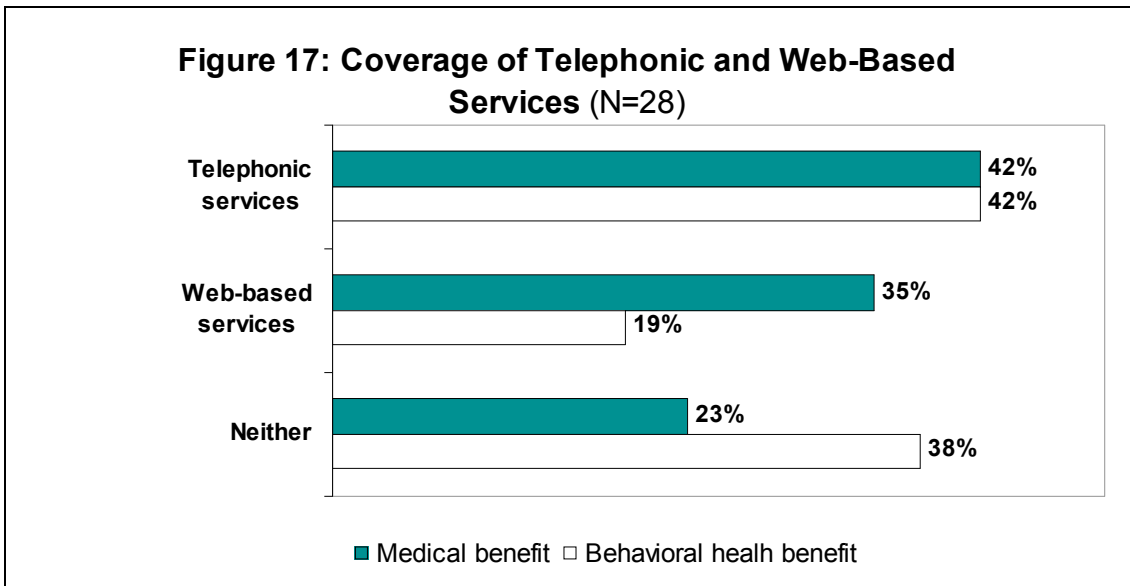
| Service | Average Ranking |
|---|-----------------|
| Recommendations by consultants | 3.4 |
| Recommendations by industry partners | 4.4 |
| Industry benchmark reports (such as EMPAQ) | 4.9 |
| Industry partners' standard plans | 5.2 |
| Reports from data warehouses | 5.3 |
| Scientific research | 5.3 |
| Recommendations by independent organizations such as the Institute of Medicine, medical organizations | 5.7 |
| Recommendations of national/local business coalitions/associations | 6.4 |
| State and federal mandates | 7.0 |
| Return-on-investment information | 7.3 |
| Risk management/concern about litigation | 9.3 |
| Other | 9.9 |
| Outcome of collective bargaining | 10.6 |

Note: For those respondents who selected "other," 1 company reported their corporate EAP Leader as ranking 2, and 1 company gave their disease management program a ranking of 3.

In follow-up to that question, employers were asked if they provided consultants with integrated behavioral health claims data. Three-fourths (75%) of employers confirmed that they did provide consultants with the claims data (Figure 16).

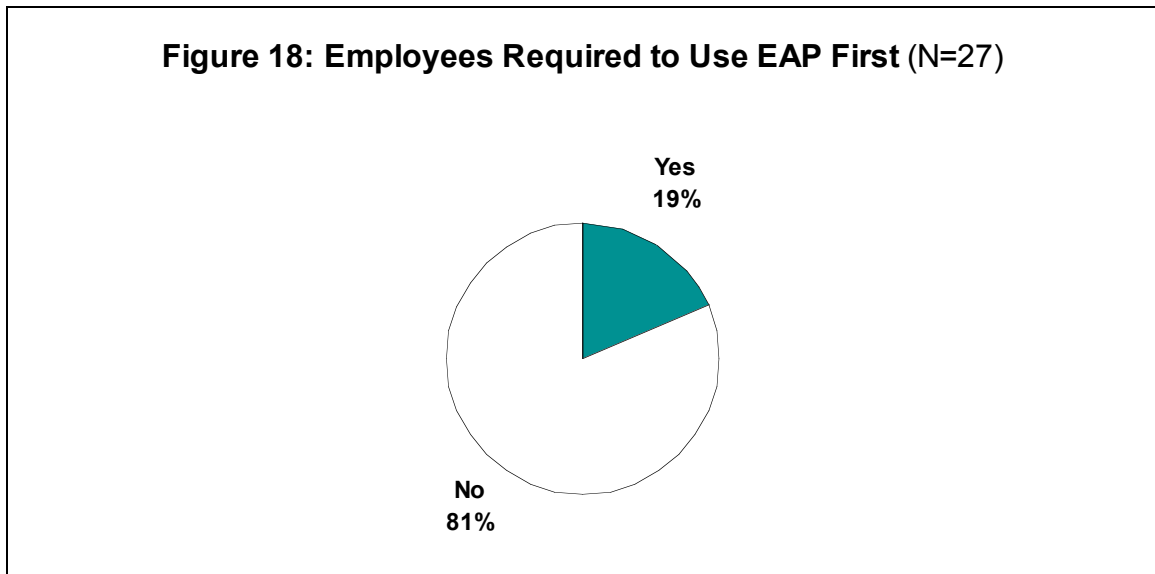


In order to determine how telephonic and web-based counseling services were covered in health plans, employers were asked if they covered either of the services and whether the service was listed under the general medical benefit or the behavioral health benefit.



Note: Respondents could indicate that they covered a service under the medical benefit and the behavioral health benefit or neither. It is possible that this type of service falls under the EAP or a disease management company. Respondents were not asked about that potential.

Employers were also asked whether employees are required to use the employee assistance program (EAP) before entering the specialty behavioral health system. As seen in Figure 18, most employers (81%) replied that employees were not required to use the EAP first.



In a follow-up question, employers were asked how many EAP sessions they allowed employees to have before referring them to other behavioral health services. It is important to note that employers varied in their responses, from 3 sessions up to 6 sessions. The mean number of sessions allowed was 4.7 (Table 3).

Table 3: Number of EAP Sessions Allowed (N=13)

| | Number of Sessions |
|---------|--------------------|
| Minimum | 3 |
| Mean | 4.7 |
| Median | 5 |
| Maximum | 6 |

When asked if employers required various types of industry partners to adopt what they consider best practice national guidelines, 16% of employers required their medical plans to adopt best practices, 33% required their PBMs, and 19% required the same of their managed behavioral health organizations (Table 4).

Table 4: Requiring Industry Partners to Adopt Best Practices (N=90)

| Service | Yes | No | Don't know |
|--|-----|-----|------------|
| Medical plan | 16% | 58% | 26% |
| PBM | 33 | 44 | 23 |
| Managed behavioral health organization | 19 | 54 | 27 |

For those employers who indicated that they require one or more of their industry partners to adopt national guidelines, they were asked if they also require those industry partners to assess the provider’s performance compared to those national guidelines. Of those who responded, 19% of employers required their medical plans to assess provider performance, compared with 18% of employers requiring the same from their PBMs and 13% of employers doing so with their managed behavioral health organizations (Table 5).

Table 5: Requiring Industry Partners to Assess Provider’s Performance (N=17)

| Service | Yes | No | Don’t know |
|--|-----|-----|------------|
| Medical plan | 19% | 50% | 31% |
| PBM | 18 | 53 | 29 |
| Managed behavioral health organization | 13 | 53 | 33 |

Employers were asked whether they provide reimbursements for particular types of behavioral health care. Most employers (71%) either required or allowed the reimbursement of visits to a primary care physician, when the visit included a behavioral health diagnosis. Alternatively, only 8% of employers require medical plans to reimburse for the development of treatment plans and monitoring of progress of patients with behavioral health conditions using standardized evidence-based benefits (Table 6).

Table 6: Require or Allow Reimbursement (N=87)

| Service Description | Yes | No | Don’t know |
|--|-----|-----|------------|
| Require primary care providers to screen patients routinely with chronic medical conditions (i.e. diabetes) for depression | 13% | 78% | 9% |
| If the primary care provider is treating a behavioral health disorder, require him/her to develop treatment plans and monitor progress of patients with behavioral health conditions using standardized evidence-based instruments | 8 | 83 | 9 |
| Reimbursement for case management/disease management for common behavioral health problems within the general medical system when the primary care physician is treating the patient | 32 | 53 | 15 |
| Reimbursement for visits to a primary care provider if the visit includes a behavioral health diagnosis code | 71 | 23 | 6 |

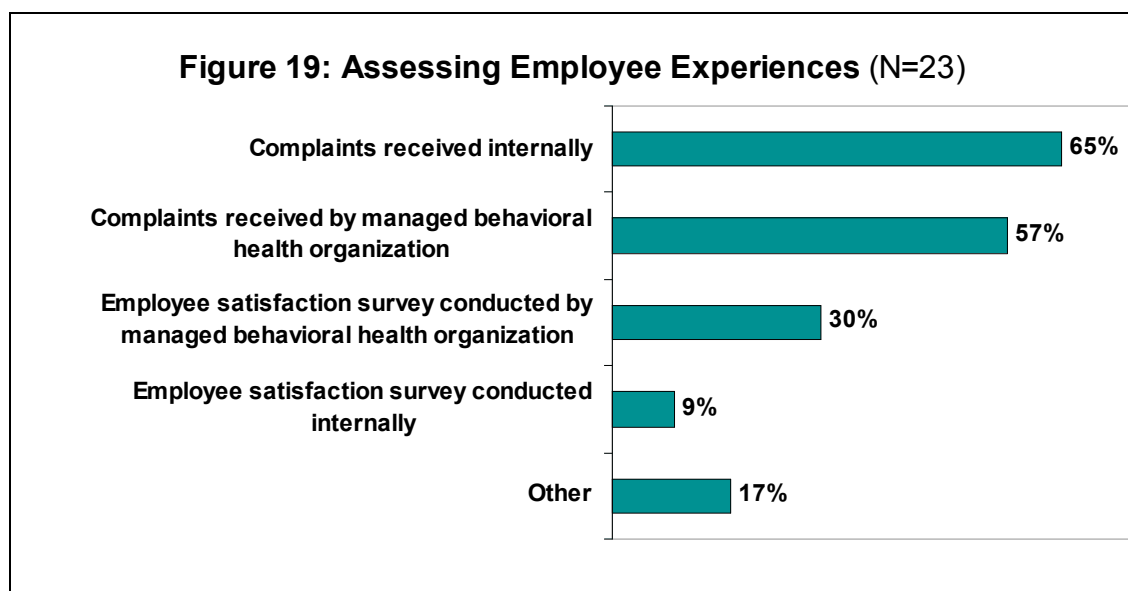
When asked what employers require of their short-term and long-term disability companies, only 20% of employers required both short-term and long-term companies to screen employees on disability due to a medical condition for depression, 10% of employers chose to require depression screenings only for those out on short-term disability and 3% require the screening only for those employees out on long-term disability. Additionally, 27% of employers require both disability companies to include a treatment plan as a condition of coverage for employees out on disability due to a

behavioral health problem, 18% require it only from short-term disability companies, and 11% require it of their long-term disability companies only.

Table 7: Require of Disability Companies (N=83)

| Service | Yes, Both | Yes, Short-term | Yes, Long-term | Neither |
|---|-----------|-----------------|----------------|---------|
| Depression screening of employees on disability due to a medical condition | 20% | 10% | 3% | 68% |
| A treatment plan as a condition of coverage for employees out on disability due to a behavioral health problems | 27 | 18 | 11 | 45 |
| Involve behavioral health specialist in review of treatment plan for employees on psychiatric disability | 27 | 16 | 12 | 45 |
| Refer employees to EAP for return-to-work assistance | 27 | 20 | 5 | 49 |

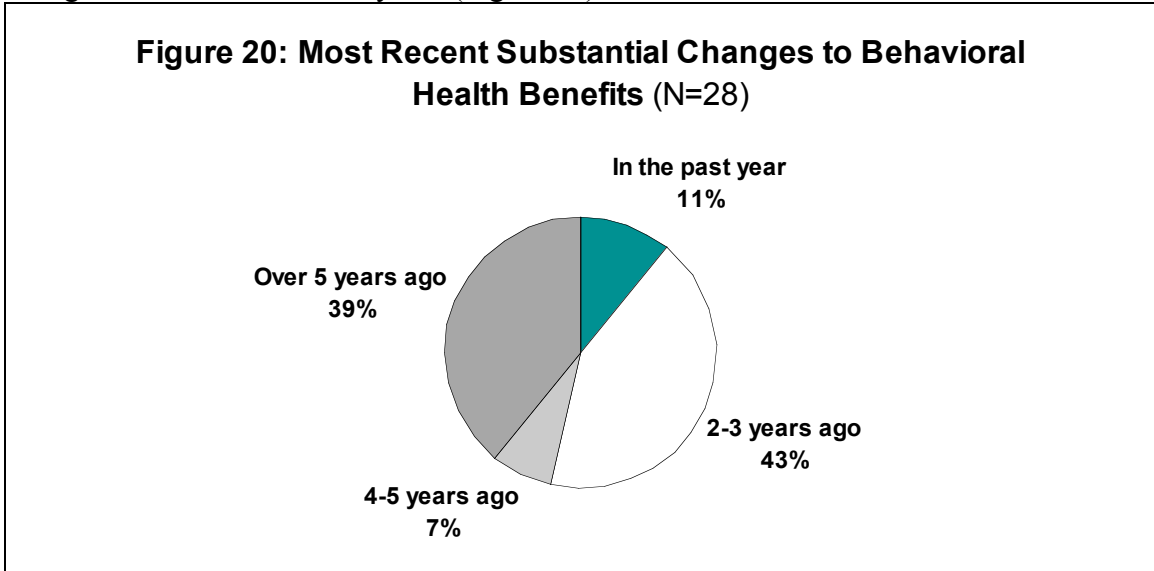
Employers were asked how they assess their employees’ experiences with the behavioral health system, and 65% of employers received complaints internally (Figure 19). Another 57% of employers reported receiving complaints through their managed behavioral health organization.



Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 1 company reported their medical plan vendor conducted a satisfaction survey, 1 said complaints were received through the medical vendor, and 2 did not have anything in place to assess employees’ experience.

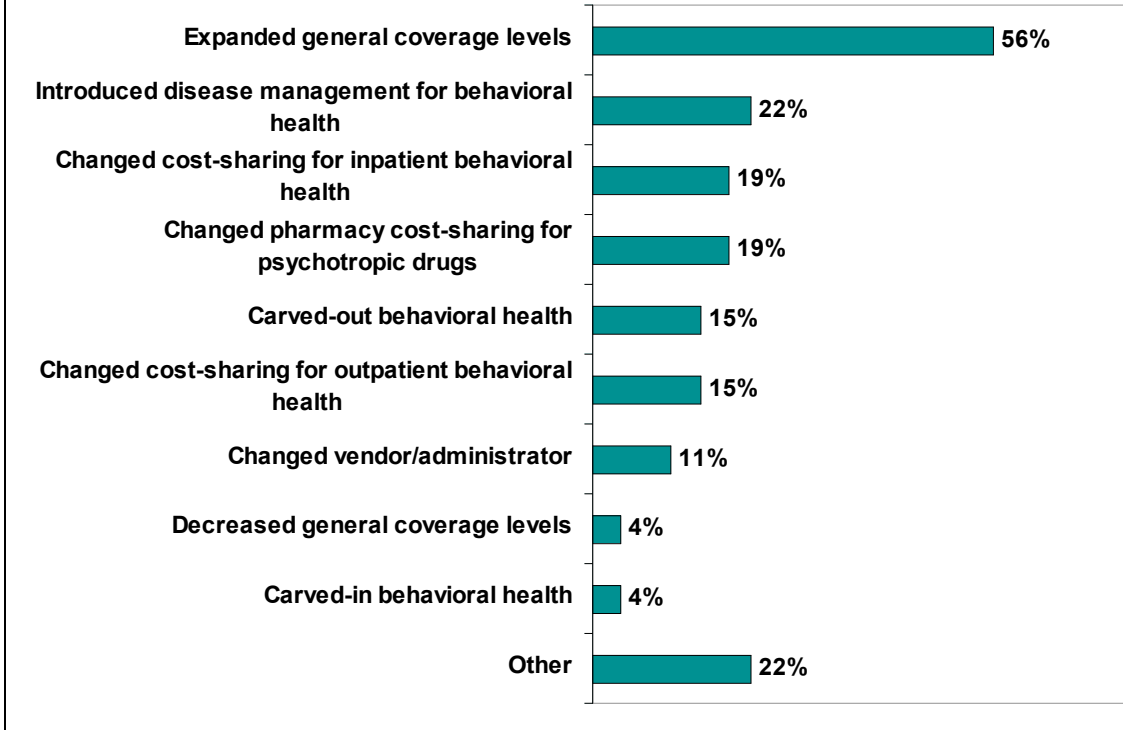
Changing Behavioral Health Benefits

Employers were asked a series of questions to better understand what types of changes they have made in recent years. More than half (54%) reported making substantial changes within the last three years (Figure 20).



When asked what types of changes had been made to behavioral health benefits recently, the majority of employers (56%) reported that they had expanded general coverage levels for behavioral health (Figure 21). Other changes included: 22% of employers introducing disease management for behavioral health, 19% changing the cost-sharing for inpatient behavioral health, and 19% changing the pharmacy cost sharing for psychotropic drugs.

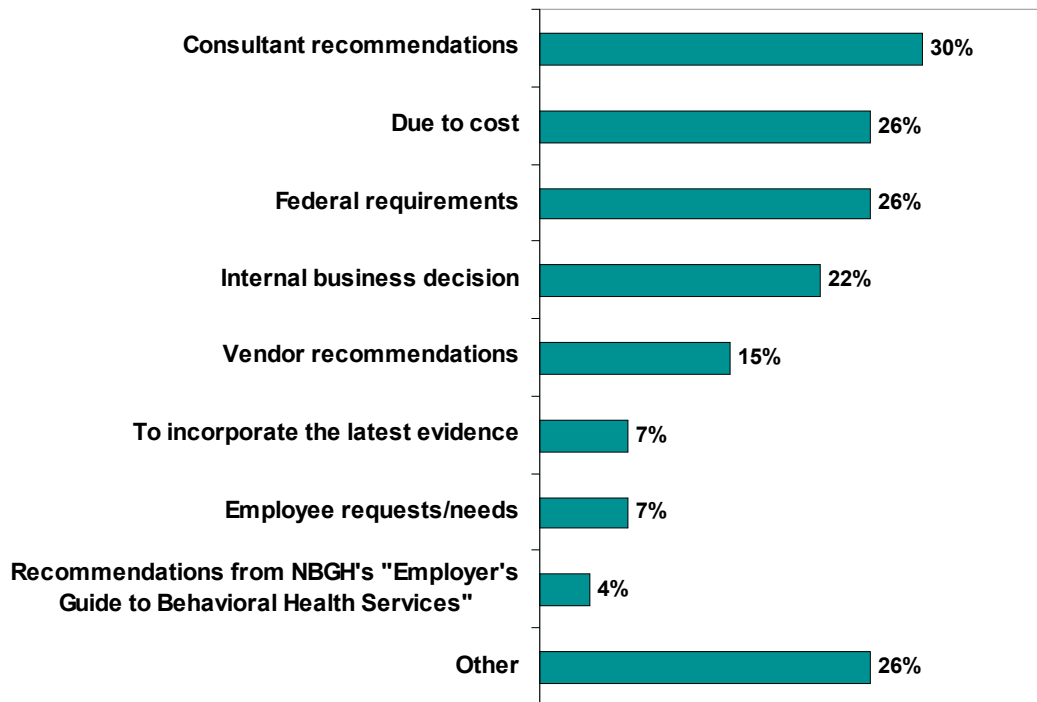
Figure 21: Types of Changes Made to Behavioral Health Benefits (N=27)



Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 1 company reported expanding their autism coverage, 1 said they removed the gate-keeper provisions to the EAP, 1 reported introducing case management and behavioral health screenings to disease management programs, and 1 company said it brought the plan into compliance with federal requirements.

Following up on that question, employers were asked why they made the recent changes. As seen in Figure 22, the most prevalent response was consultant recommendations (30%), followed by cost (26%) and federal requirements (26%).

Figure 22: Reasons for Implementing Most Recent Changes (N=27)

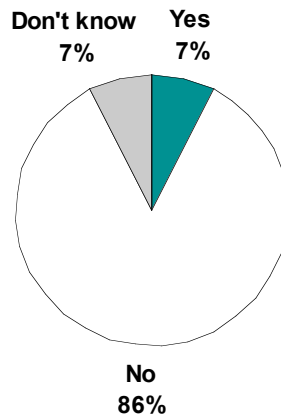


Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 1 company reported updating coverage levels, 1 said Rx coverage was expanded based on medical evidence and recommendations, 1 reported changes were made to ease administrative challenges, 1 said it wanted to formalize residential treatment center benefits, and 1 reported changes were made to ensure employee coverage.

Employers were asked if either they or their medical plans had implemented any programs to address the lack of psychiatrists, especially pediatric psychiatrists, in certain areas, and most (85%) responded that they did not have any programs in place (Figure 23).

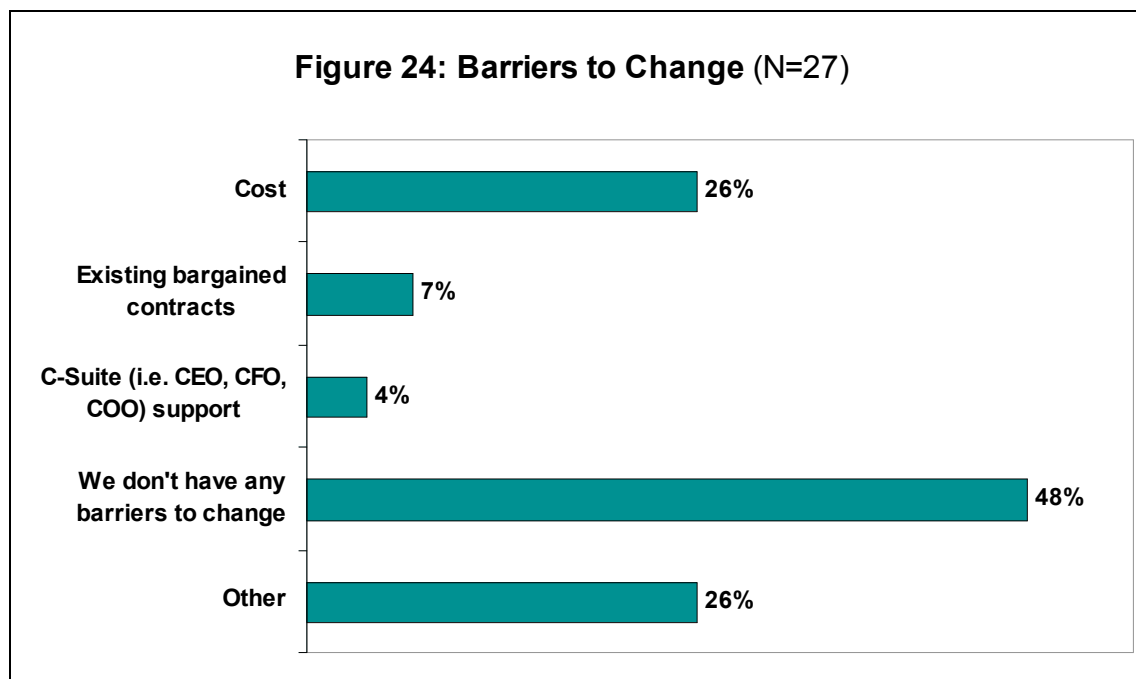
Figure 23: Programs to Address Lack of Psychiatrists

(N=27)



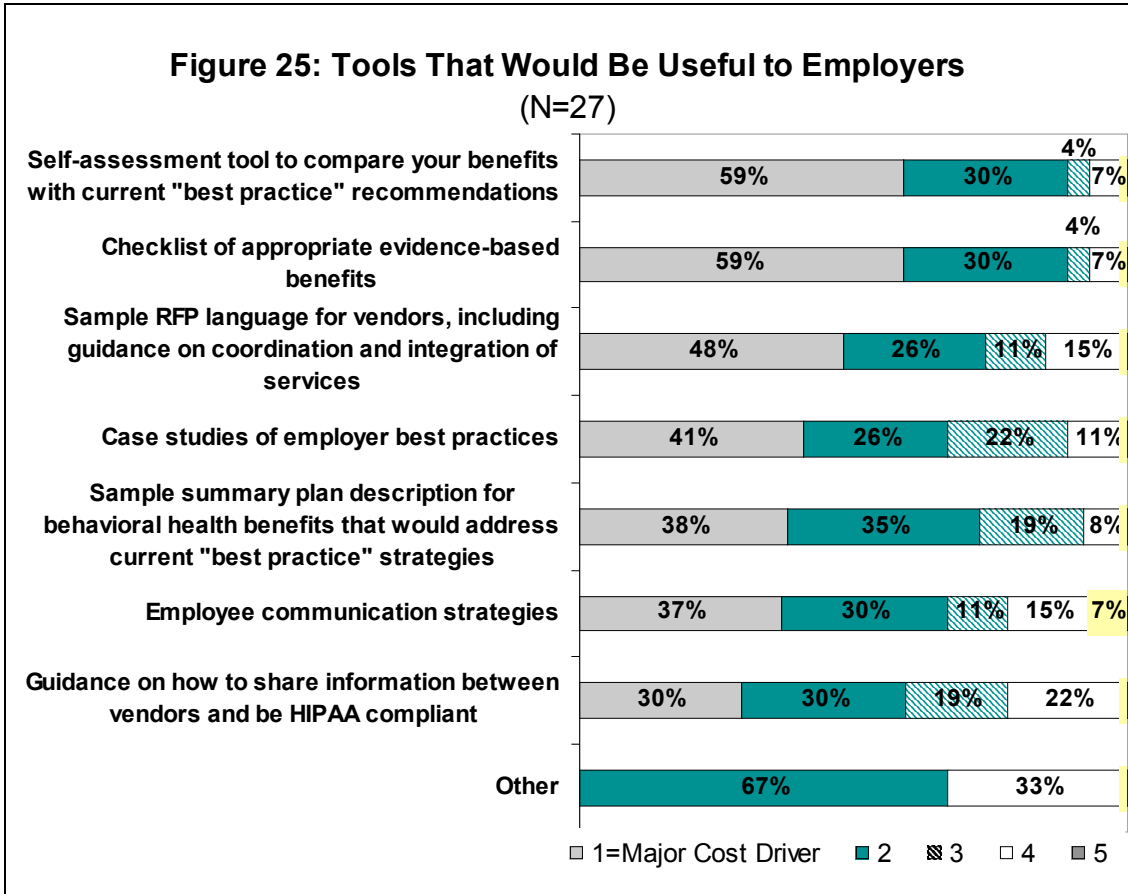
When asked about barriers to change, nearly half of the respondents (48%) reported that they did not perceive any barriers to changing behavioral health benefits (Figure 24). On the other hand, 26% of employers reported that cost is a barrier to change in their organization.

Figure 24: Barriers to Change (N=27)



Note: Respondents could provide more than one answer. And for those respondents who selected “other,” 2 companies reported that it wasn’t a top priority, 1 said it was concerned about confidentiality and employee perception, 1 reported that the behavioral health vendor being used hadn’t brought up any concerns, and 1 company reported a lack of clear direction.

To assist in the development of a toolkit being developed by the Business Group, employers were asked which tools would be most useful to them on a scale of 1 to 5 (with 1 being very useful and 5 being not useful). As seen in Figure 25, employers reported that self-assessment tools to compare benefits with current “best practice” recommendations and checklists of appropriate evidence-based benefits would be the most useful.



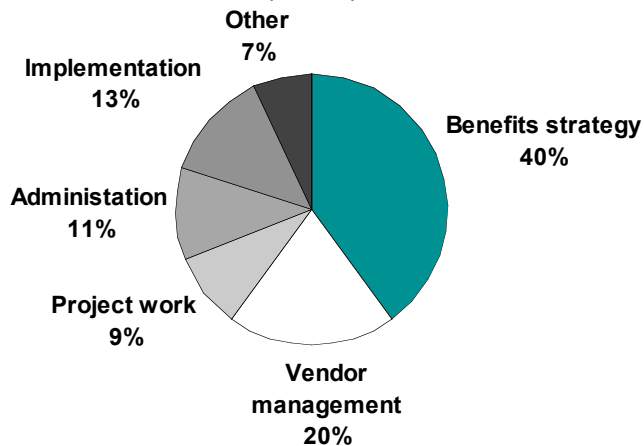
Note: For those respondents who selected “other,” 1 company reported that it would be useful to have studies on potential ROI of an integrated approach as well as to have tools to assess the impact of depression and other behavioral health issues on productivity.

Respondent Profiles

In order to understand who was answering this survey, respondents were asked a couple of questions concerning their level of involvement in behavioral health benefits. The first question asked how they spent their time on various work activities. On average the respondents spent 40% of their time on benefits strategy, 20% on vendor management, 13% working on projects, 11% on administrative tasks, 9% on implementation, and 7% on other tasks (Figure 26).

Figure 26: Average Time Spent on Various Work Activities

(N=25)



On a scale of 1 to 10 (where 1 means no impact and 10 equals key decision maker) employers were asked to rate their role in the decision making of behavioral health benefits. The average score was 8, suggesting that respondents have considerable impact in the decision making process for behavioral health benefits (Table 8).

Figure 27: Level of Impact on Behavioral Health Benefits

(N=24)

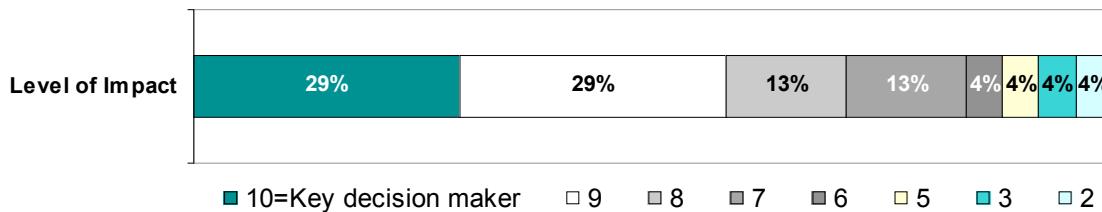


Table 8: Level of Impact on Behavioral Health Benefits (N=24)

| | Level of Impact |
|---------|-----------------|
| Minimum | 2 |
| Mean | 8 |
| Median | 9 |
| Maximum | 10 |

Task 1.2: Industry Interviews with Leading Stakeholders on Behavioral Health Strategies and Productivity

This section summarizes findings from the National Business Group on Health's interviews with industry stakeholders on behavioral health strategies and productivity. The purpose of these interviews was to obtain a better understanding of consultant and industry specialist recommendations on behavioral health strategies for large employers. These experts provided their opinions on the latest trends and issues as it relates to providing behavioral health benefits to employees of large employers. From February 1 to March 30, 2009, interviews were conducted with the following 17 industry stakeholders:

- 6 benefits consulting firms,
- 5 managed behavioral health organizations,
- 2 pharmacy benefit managers,
- 2 employee assistance programs and
- 2 data warehousing firms.

Appendix B provides a list of the companies that we interviewed as part of this project.

Benefits Consulting Firms

Most consultants agreed that behavioral health is not on the “radar screen” of many employers and that many employers are not investing enough in programs and services related to behavioral health. This lack of investment comes from the false belief that behavioral health does not constitute sizable enough cost components for them to take further action. However, this falsity stems from a narrow view of behavioral health costs as only being related to medical and pharmacy claims, rather than taking into account disability costs, absenteeism and presenteeism. In addition, a stigma exists with diagnosing mental health problems, which may lead to underreporting of behavioral health diagnoses and underestimating of behavioral health costs.

Several consultants believe that the passage of the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 (“mental health parity legislation”) represents an unprecedented opportunity for employers to focus on their behavioral health benefits and consider what is appropriate coverage.

However, with the new law comes much confusion on how to proceed. One consultant said that leeway exists in how much to invest in behavioral health, since parity legislation does not require the use of mental health definitions established in the Diagnostic and Statistical Manual of Mental Disorders. Another felt that the passage of this legislation meant there would be a significant shift in the market, as more firms move away from carved out behavioral health benefits to carved-in as a way to ensure coordination of deductibles and out-of-pocket maximums with the medical benefits. However, not all consultants believed this shift was necessary. As long as there was integration of data between industry partners, some consultants thought a carved-out benefit would continue to work under parity.

Most consultants agreed that integration of medical and behavioral health claims data is a big challenge. An employer's ability to integrate data rests on the technological capabilities of its many industry partners: health plan, managed behavioral health organization (MBHO) if applicable, pharmacy benefit managers, disability companies, data warehousing firms and employee assistance programs. As a result, consultants are telling employers to convene their partners at a summit to evaluate existing programs for integration ability. To demand stronger reporting and administrative efficiency, one consultant urged employers to conduct aggressive vendor selections, renewal evaluations, performance reviews and contract reviews.

In addition to data integration, consultants have been advising employers on ways to ensure coordination of care. For example, one consultant advised employers to integrate behavioral with medical care using screenings and referrals by primary care providers to examine co-morbid conditions. This recommendation was the direct result of the fact that primary care providers currently provide behavioral health care and are large prescribers of psychotropic drugs. Another consultant recommended using predictive modeling on claims or health risk assessment data to identify employees in need of further care. This care could be provided through a disease management program targeting behavioral health issues or other support programs.

Some consultants mentioned workforce stress as another area of concern. One consultant reported seeing a noticeable uptick in EAP calls for legal and financial consultations at the beginning of 2009. However, another consultant reported not hearing much about it or seeing anything on the impact of stress on productivity. One consultant noticed a rise in requests for autism, since an employer may already cover some treatment under medical but may choose to cover more under their behavioral benefits due to parity.

Managed Behavioral Health Organizations (MBHOs)

MBHOs understand that data integration must be a priority. However, the interviews with MBHOs highlighted that each MBHO differs in its approach and ability to integrate and analyze behavioral and medical data. While some MBHOs are owned by national health plans and can therefore integrate in-house with medical, other MBHOs are standalone behavioral specialty companies that must work with separate medical companies. Despite the hurdles of integration of data, MBHOs are indicating they have found ways to effectively do just that. For example, one MBHO is able to provide medical and behavioral case management, by combining medical and pharmacy data with EAP and disability data.

Compared to other stakeholders, MBHOs believe that employers are beginning to recognize the importance of their behavioral health benefits, although there is still a need for more education. One MBHO says that employers used to ignore behavioral health and substance abuse because they perceived that such conditions constituted a small percent of total medical expenditure. Now, however, employers are changing and looking at both direct and indirect costs. An MBHO reported that employers are just beginning to understand the pervasive effects of depression and substance abuse.

MBHOs agreed that employers are becoming more receptive to innovations in how behavioral health benefits are provided. For example:

- One MBHO that integrates medical/pharmacy data with behavioral data for their clients recently began offering disease management programs to their employers for depression, alcohol, eating disorders and autism. This new offering was a direct result of the fact that with the integrated data they could easily identify employees who would benefit from the program and could steer them to the program. This MBHO also serves as case management partners for treating comorbid behavioral health conditions for people with diabetes and heart failure.
- With respect to primary care, one vendor is developing a model using differentiate levels of cost-sharing as an incentive to influence patient behavior that integrates the behavioral health specialist into the primary care setting.
- One MBHO launched a pilot project that screens patients who are out on medical disability for behavioral health issues. This MBHO uses a standardized instrument that helps medical case managers assess bodily symptoms, such as back pain and headaches, which may have resulted from depression.

MBHOs see a connection with the role of EAPs. One MBHO supports the EAP as a fantastic, but under-utilized, resource by placing it as the foundation of its wellness program for behavior change. During the 4th quarter of 2008, this MBHO saw 60% more EAP calls, especially for employers with downsizing and layoffs. Another MBHO sees a global uptake of EAP services for workplace difficulties and stressed-based issues around life/work balance and general anxiety and believes that MBHOs and EAPs should work together to assist employees in need.

Pharmacy Benefits Managers

Both PBMs interviewed have been working to coordinate with disease management companies. This coordination focuses on identifying patients for disease management programs through the first prescription fill. The PBMs have taken this approach for cardiovascular and diabetes patients, and feel that the same can be done for patients with behavioral health conditions. Because it is known that a large percentage of prescriptions for antidepressant drugs are filled by patients who never have a behavioral health diagnosis, the PBMs felt that identifying people via their prescriptions was an effective way to ensure patients who should be in the behavioral health system get there. When a new prescription for a psychotropic is submitted through the pharmacy benefit, the PBM then provides information to the disease management company to ensure the patient gets the appropriate behavioral care.

PBMs would like to further integrate with other stakeholders. Because pharmacy data can provide a wealth of information, PBMs would like to interact more closely with employee assistance programs and MBHOs. However, they have had some resistance from MBHOs and PBMs agree that any effort at further coordination would have to be driven by the employers.

PBMs are seeing employers focus more on adherence and compliance issues. Although overall mental health costs have not been on most employers' 'radar screens,'

the use of psychotropics has been one of the top drivers of pharmacy costs. As a result, there has been a focus by employers on adherence/compliance programs for patients on medications for depression. One PBM recommends that employers adopt a multi-pronged approach, starting with generics and tying in step therapy. The other PBM reported that in light of the current economic recession, employers are more willing to accept its previous recommendations such as mandating use of mail service and utilization management. It also noticed that employers are even implementing changes off cycle (mid-year) and not waiting for the annual contract renewal window.

Employee Assistance Programs

Both EAP interview participants see the economic crisis as a significant driver of calls for financial and bankruptcy counseling/support and disaster planning. They see workers calling for help around layoffs, and even workers who remain employed are still under stress. One EAP provider said that disability claims have gone up slightly, possibly due to depression and alcohol abuse. Overall, these issues are more serious than before the economic crisis.

Participants felt that proving the value of EAPs to employers has been difficult.

Many employers do not understand that good EAPs can mitigate stress, enhance resilience, change rates of absenteeism/presenteeism and improve employee retention. One EAP provider reported working with a group to devise a signal system that defines and quantifies EAP activities for optimizing program performance for the employer performance. Success can be based on industry norms relating to absenteeism and presenteeism.

EAP providers felt the term, EAP, limits utility and rather the program should be leveraged for human behavior performance in a healthy and productive workplace.

Participants encourage employers to rename the EAP to life solutions or resources to improve visibility and acceptability. Employers should find ways to transition EAP to top of mind and integrate EAP with the medical plan to bridge human work/life balance and talent. Employers should minimize any cultural stigma in seeking EAP help and work on improving EAP operations and technology.

Data Warehousing Firms

In the last several years, both data warehousing firms felt that overall interest in behavioral health has declined; in other words, managed behavioral health is part of the discussion when it shows up in the ‘top 10’ list of major cost drivers but no action is taken because generally employers will focus on other bigger cost trends. The only time that one firm remembered behavioral health was part of a discussion was when the analysis showed high use of psychotropic drugs. Furthermore, in cases where behavioral health claims were high, the firms believe that employers were uncertain about whether to do anything or even what steps were actionable.

Participants believed that employers are asking more about data integration and assessing health from an overall perspective which includes productivity, incidental absenteeism and short- and long-term disability. The impact of parity legislation presents employers with new questions on how to equalize behavioral and medical

benefits (i.e., to carve in or carve out with respect to behavioral health). As a result, the need for integrated data is all that much more important.

With the decline in the economy, the firms feared that any steps toward integration and ultimately helping to prove the true cost of behavioral health will be halted as many employers now have tighter budgets. With tighter budgets, employers may not hire data warehouses and thus will be unable to integrate data and understand true costs.

Conclusion

The findings from Task 1.1 and Task 1.2 highlight four important themes:

- Employers need to be better informed about total behavioral health costs. Employers perceive behavioral health care as a ‘black hole’ and often rely on consultants and industry partners for direction. However, an uneven level of knowledge exists in the marketplace making it difficult to ensure employers are consistently receiving accurate and reliable information.
- Because of the lack of education on how behavioral health impacts the workforce and company as a whole, there is a great need for better integration of the data related to both direct and indirect costs of behavioral health. It is only once data is integrated can employers understand what they have and what the impact is on the workforce, health plan beneficiaries and company profitability.
- The passage of the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 is forcing employers to refocus on the topic of behavioral health benefits and change the way they evaluate these benefits. The attention provided as a result of the law provides a unique opportunity to educate employers on the appropriate types of benefits they should provide.
- Once employers understand the impact of behavioral health on their company, they need actionable steps to improve their behavioral health benefits. These actionable steps should include following established protocols as well as selecting and monitoring the industry partner that implement these protocols. Employers should maximize the value they receive from industry partners by forcing them to effectively integrate their data in proving return-on-investment to executive management.

Appendix A: Survey Participants

Member Companies Agreeing To Be Listed

| | |
|--------------------------------|--------------------------------|
| AB Volvo | Medtronic |
| ABM Industries | Metavante |
| Accenture | Microsoft |
| Aetna | Motorola |
| B. Braun Medical | Nike |
| Baker Hughes | Owens Corning |
| Board of Pensions, PCUSA | Peabody Energy |
| Cardinal Health | Perdue Farms Incorporated |
| Chevron | Pfizer |
| Corning Incorporated | PPG Industries, Inc. |
| Cummins Inc. | Principal Financial Group |
| CVS Caremark | Quest Diagnostics Incorporated |
| DuPont | Raytheon Company |
| Edward Jones | Reader's Digest |
| Fairfax County Public Schools | Rockwell Automation |
| FedEx Express | Saint-Gobain Corp |
| Fiserv Inc. | The Boeing Company |
| General Electric Company | The Dow Chemical Company |
| General Mills, Inc. | Time Warner Inc. |
| General Motors | Tyson Foods |
| GlaxoSmithKline | Universal Health Services |
| H-E-B | University of California |
| Hewlett Packard | Unum |
| Intel | Verizon Communications |
| Kansas Health Policy Authority | Visant |
| Kellogg Company | Visteon Corporation |
| Kinder Morgan | Wells Fargo |
| Liberty Mutual | Wendy's International, Inc |
| Lowe's | Whirlpool Corporation |
| Marriott | WPP Group USA Inc. |
| McDonald's Corporation | Xcel Energy |

Appendix B: Stakeholder Interview Participants

Benefit Consultants

Aon
Hewitt & Associates
Milliman, Inc.
Mercer
Towers Perrin
Watson Wyatt Worldwide

Managed Behavioral Health Organizations

Aetna
CIGNA
Magellan
Optum Health
Value Options

Pharmacy Benefits Managers

Express Scripts
Medco

Data Warehousing Firms

Ingenix
Thomson Reuters

Employee Assistance Program Providers

Burke Consulting
Optum Health