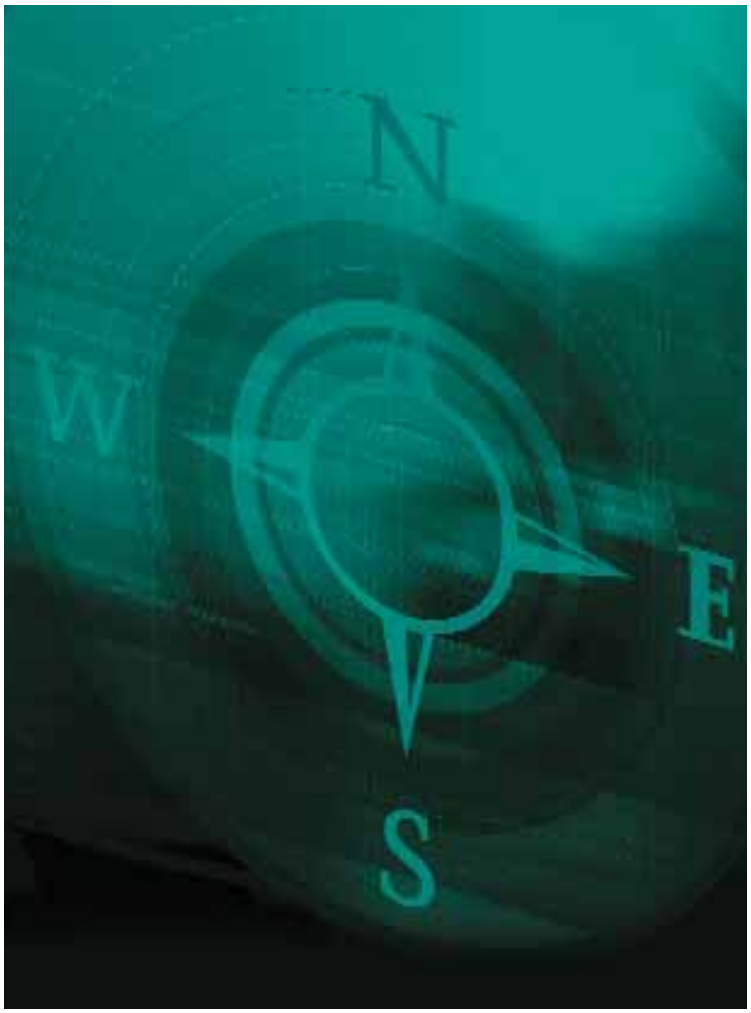
Center for Prevention and Health Services

National Business Group on Health

AN EMPLOYER'S GUIDE
TO BEHAVIORAL HEALTH SERVICES

A roadmap and recommendations for evaluating, designing and implementing behavioral health services



- **Major Trends in the Epidemiology, Treatment and Cost of Behavioral Healthcare in the United States**
- **The State of Employer-Sponsored Behavioral Health Services in the United States**
- **Recommendations to Improve the Design, Delivery, and Purchase of Employer-Sponsored Behavioral Healthcare Services**

- **Overview of the President's New Freedom Commission on Mental Health**
- **Measuring Quality in Behavioral Healthcare**

What is Behavioral Healthcare?

Behavioral healthcare is an umbrella term and refers to a continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders. Behavioral health, as a discipline, refers to mental health, psychiatric, marriage and family counseling, and addictions treatment, and includes services provided by social workers, counselors, psychiatrist, psychologists, neurologists, and physicians. In this publication, the term "employer-sponsored behavioral healthcare services" refers to all employer-sponsored services that address mental health or substance abuse problems including services offered through the health plan, disability management programs, EAP, and health promotion or wellness programs.

What is a Mental Illness?

Mental illness/behavioral health disorder (also known as mental disorder): is a health condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof), that is mediated by the brain and associated with distress and/or impaired functioning. Mental disorders cause a host of problems that may include personal distress, impaired functioning and disability, pain, or death.

Serious emotional disturbance (SED): A diagnosable mental disorder found in persons from birth to 18 years of age that is so severe and long lasting that it seriously interferes with functioning in family, school, community, or other major life activities.

Serious mental illness (SMI): A SMI is defined as a diagnosable mental, behavioral or emotional disorder that meets the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and causes functional impairment that limits one or more major life activities. Examples of individuals who meet these criteria include those adults with: mood disorders (major depression, dysthymia, mania); anxiety disorders (panic disorder, generalized anxiety disorder, phobia, post-traumatic stress disorder); antisocial personality disorder, schizophrenia, and other non-affective psychoses.

Serious and persistent mental illness (SPMI): Individuals with the most severe types of Serious Mental Illness and who have the most severe functional limitations can be said to have serious and persistent mental illness (SPMI).

What is a Substance Abuse Disorder?

In this publication, a substance abuse disorder refers to either substance abuse or substance dependence. Substance abuse is the problematic use of alcohol or drugs occurring when an individual's use of alcohol or drugs interferes with basic work, family, or personal obligations. Substance dependence is a clinical diagnosis that is made when an individual using alcohol or illicit drugs meets at least three of the six criteria set forth in the DSM-IV for either alcohol or drug dependence including a strong desire to use the substance, a higher priority given to use than to other activities and obligations, impaired control over its use, persistent use despite harmful consequences, increased tolerance, and a physical withdrawal reaction when use is discontinued. Substance abuse and dependence can occur with the use of alcohol, illicit drugs, and prescription medications.

Sources: Department of Health and Human Services. Healthy People 2010. Chapter 18 – Conference Ed. Mental Health and Mental Disorders. Referenced on the SAMHSA Website. Terminology of Mental Disorders. http://www.mentalhealth.samhsa.gov/features/hp2010/terminology.asp. Accessed 8-24-05; World Health Organization. Lexicon of alcohol and drug terms. Available at: http://www.who.int/substance_abuse/terminology/ who_lexicon/en/index.html. Accessed 10-3-05.

Executive Summary

Introduction

The delivery of behavioral healthcare is relatively complex when compared to the delivery of general medical care. The industry annually generates more than $104 billion in direct care expenses and continues to experience rapid reorganization and realignment of services in response to purchaser demands. Employer, federal, state, and local government purchasing strategies continue to change in response to price and demand for behavioral healthcare services.

The complexity of the behavioral healthcare provider market has resulted from a combination of events and issues, including benefit design, payer and individual provider expectations, and new provider entrants into the marketplace. Major trends, such as consumer-driven healthcare, have and will continue to affect the delivery of behavioral healthcare. Both payers and providers need to carefully analyze the influence these trends have, and will continue to have, in shaping the delivery of care.

Recently, there has been an increased focus on the effective delivery of behavioral health services. The federal government as well as a number of other agencies and organizations have released landmark reports that chronicle the promise of timely, high-quality, and evidence-based behavioral health services for recovery, including the:

- *Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services; 1999)*. The first ever Surgeon General's report on behavioral health presented the evidence to support a wide range of effective treatment modalities.
- *President's New Freedom Commission Report on Mental Health: Achieving the Promise — Transforming Mental Health Care in America (U.S. Department of Health and Human Services; July 2003)*. The taskforce, established by the President, examined the failings and successes of the public mental healthcare system and established six goals for improving behavioral healthcare in America.
- *Improving the Quality of Healthcare for Mental and Substance Abuse Conditions (The Institute of Medicine; November 2005, Quality Chasm Series)*. This report describes a multifaceted and comprehensive strategy for ensuring access, improving quality, and expanding mental health and substance abuse treatment services.

Employers understand that behavioral health benefits are essential components of healthcare benefits. Over the past few decades, employers have tried to improve the delivery of behavioral healthcare services in a number of ways. Despite important progress, employers' current approaches to managing cost and quality are insufficient. Standardized and integrated programs addressing the delivery of behavioral healthcare services remain rare. And unfortunately, it is not customary for employers to integrate behavioral healthcare benefits offered through the health plan with behavioral health benefits offered through disability management, employee assistance, or health promotion programs. The result is that employer-sponsored behavioral benefits are fragmented, uncoordinated, duplicative, and uneven in terms of access and quality.

Employers have been at the forefront of quality improvement in healthcare and have established quality measures, review processes, evaluation tools, and other means of promoting the quality of the healthcare services they sponsor. Most employers have focused their quality promotion efforts on general healthcare services. Now, employers need to focus on promoting the quality of the behavioral healthcare services they sponsor.

The National Business Group on Health (Business Group) has a strong history of addressing employer-sponsored behavioral healthcare services. Yet, until now, the Business Group has never released a comprehensive *Guide* on evaluating, designing, and implementing behavioral health benefit design.

Purpose of the Guide: A Blueprint for Action

This *Guide* is a blueprint of actionable strategies and recommendations that will allow employers to create and implement a system of affordable, effective, and high-quality behavioral health services. The recommendations featured in this *Guide* are based on the best-available administrative and clinical practices; these practices have years of evidence to support their immediate and widespread implementation.

The findings and recommendations presented in this *Guide* provide a process for employers to examine their current behavioral health benefits and services and to develop contracting requirements to guide their selection of future health plans, Managed Healthcare Organizations (MCOs), Managed Behavioral Healthcare Organizations (MBHOs), disability managers, Pharmacy Benefit Mangers (PBMs), and Employee Assistance Vendors (EAPs).

Specifically, this *Guide* provides information for employers to:

- Improve coordination among health management programs and vendors.
- Standardize the delivery of behavioral health services and programs, whether developed in the general medical setting or the specialty behavioral health system.
- Include evidence-based treatment modalities in behavioral health benefit structures.
- Develop enhanced programs and measures of continuous quality improvement.
- Promote quality and accuracy in the practice of prescribing psychotropic drugs.
- Improve the efficacy of disease management programs for chronic medical conditions by including behavioral health screening and treatment.

The goal of the *Guide* is to help employers:

- Increase employee health status
- Manage employee productivity
- Control the cost of healthcare and disability

Approach

The National Business Group on Health, funded by the Department of Health and Human Services' (DHHS) Center for Mental Health Services (CMHS), convened the *National Committee on Employer-Sponsored Behavioral Health Services (NCESBHS)* in January 2004. The Committee was established to review the current state of employer-sponsored behavioral health services and to develop recommendations to improve the design, quality,

structure, and integration of programs and services. The *Committee* was also charged with reviewing the recommendations of the President's New Freedom Commission on Mental Health and determining how they might apply to employer-sponsored behavioral health benefits and programs. (For more information on the President's New Freedom Commission Report on Mental Health, please see *Appendix A: The President's New Freedom Commission Report on Mental Health*).

The *Committee* consisted of 25 benefits and healthcare experts including academic researchers, disability management professionals, Employee Assistance Program (EAP) professionals, healthcare benefits specialists, representatives from managed care and managed behavioral health organizations, pharmacology experts, and medical directors and benefits managers from Business Group member companies. Several members of the NCESBHS have served on national boards, expert panels, and federal commissions dedicated to the improvement of behavioral healthcare, including the Institute of Medicine Board, the President's New Freedom Commission on Mental Health, and the Surgeon General's Report on Mental Health. (See *Appendix C: Acknowledgements* for a list of *Committee* members and their affiliation)

Summary of Key Findings

The *Committee's* review resulted in twelve key findings. They are summarized as follows:

1. **Mental illness and substance abuse disorders are serious, common, and expensive health problems.**
   In 2001, mental health and substance abuse treatment costs totaled $104 billion and represented 7.6% of total healthcare spending in the United States ($1.4 trillion).[1] Unlike other medical conditions such as heart disease or diabetes, the indirect costs associated with mental illness and substance abuse disorders commonly meet or exceed the direct treatment costs.

2. **Research has conclusively shown that depression and other mental illness and substance abuse disorders are a major cause of lost productivity and absenteeism.**[2,3,4]
   Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis.[3] Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing Unites States employers $17 billion each year.[4] In total, estimates of the indirect costs associated with mental illness and substance abuse disorders range from a low of $79 billion per year to a high of $105 billion per year (both figures based on 1990 dollars).[5,6]

3. **Disability costs related to psychiatric disorders are high and continue to rise.**
   Mental illness and substance abuse disorders represent the top 5 causes of disability among people age 15-44 in the United States and Canada (not including disability caused by communicable diseases) [Note: includes employed and unemployed populations].[7] Further, mental illness and substance abuse disorders, combined as a group, are the fifth leading cause of short-term disability and the third leading cause of long-term disability for employers in the United States.[8]

4. **The efficacy of treatment for mental illness and substance abuse disorders is well documented and has improved dramatically over the past 50 years.**[9]
   For most mental illnesses there is a range of well-tolerated and effective treatments. Current research suggests that the most effective method of treatment is multimodal and combines pharmacological management with psychosocial interventions such as psychotherapy.[9]

5. **A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting, which has become the "de-facto mental healthcare system."**[10]
   Among patients diagnosed with a mental illness, 42% of those with clinical depression and 47% of those with generalized anxiety disorder (GAD) were first diagnosed by a primary care physician.[11] Approximately 22.8% of individuals treated for a mental illness or substance abuse disorder[12], and half (51.6%) of patients treated for depression, are treated by a general medical provider such as a primary care physician.[13] Further, it is estimated that 11%-36% of patients presenting at primary care have a mental illness.[11] Numerous studies over the past two decades have found that the adequacy and quality of mental healthcare delivered in the general medical setting is sub-optimal.[12] In fact, the *National Co-morbidity Survey Replication* (NCS-R) found that only 12.7% of individuals treated in the general medical sector received minimally adequate care compared to 43.87% of patients treated in the specialty mental health sector.[12]

6. **Primary care physicians (PCPs) and other general medical providers are — and will continue to be — an integral part of behavioral healthcare in the United States.**
   However, significant quality problems have been found with general medical providers' screening, treatment, and monitoring practices. Many of the recommendations presented in this *Guide* suggest programs, benefits, and practices that will support general medical providers in the provision of high-quality behavioral healthcare services.

7. **Psychotropic drugs have become the major treatment modality in behavioral healthcare whether prescribed by general medical physicians (e.g., primary care physicians) or by behavioral health specialists (i.e. psychiatrists).**
   The availability of prescription medications as a method of treatment has improved the lives of many individuals with mental illness and substance abuse disorders. However, a number of quality problems have been identified with current psychotropic medication prescribing practices (e.g., pharmacological management is frequently the sole treatment modality). Further, the escalating cost of psychotropic drugs is of concern to employers. In 1987, psychotropic medications were responsible for 7.7% of all mental healthcare spending in the United States (including expenditures from private insurance, Medicare, Medicaid, etc); by 2001, psychotropic drug spending was responsible for 21.0% of total mental health spending.[14] In 2001, private employers spent approximately 17% of their total behavioral health expenditures on prescription medications.[1]

8. **While employers have focused their attention on the management of high cost chronic medical conditions (e.g., heart disease and type 2 diabetes), such management efforts have not fully addressed the significant additional burden of co-morbid mental illness. Access to specialty behavioral healthcare services is**

critical to delivering effective disease management services for chronic medical problems. Therefore, limitations on behavioral healthcare benefits may limit the efficacy of disease management programs for individuals with co-morbid medical and behavioral health conditions. Disease management programs will not realize their full potential without fostering better coordination between the general medical healthcare system and the specialty behavioral healthcare system.
Research has shown that individuals with chronic medical conditions and untreated co-morbid mental illness or substance abuse disorders are the most complicated and costly cases. For example:

- Healthcare use and healthcare costs are up to twice as high among diabetes and heart disease patients with co-morbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.[15,16]
- Patients with mental illness and substance abuse disorders are often less responsive to treatment. For example, depressed patients are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.[17]
- The presence of type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28.5% of diabetic patients in the United States meet criteria for clinical depression.[16]
- Approximately one in six patients treated for a heart attack experiences major depression soon after their heart attack and at least one in three patients have significant symptoms of depression.[17]

9. **Access to specialty mental healthcare services is constrained due to benefit design with higher co-pays, visit limits, and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting.**
This has created a perverse incentive for patients to a.) access mental healthcare from general healthcare providers (where there are no visit limitations and co-pays are significantly lower) and to b.) rely on psychotropic medication as an exclusive method of treatment.

10. **Limiting behavioral healthcare services can increase employers' non-behavioral direct and indirect healthcare costs.**
One study found that limiting employer-sponsored specialty behavioral health services increased the direct medical costs of beneficiaries who used behavioral healthcare services by as much as 37%.[18] Further, the specialty behavioral health service limitation substantially increased the number of sick days taken by employees with behavioral health problems. The study concluded that savings attributed to limiting behavioral health benefits were fully offset by increased use of other medical services and lost workdays.[18]

11. **Employers have tightly managed behavioral health benefits delivered by the specialty mental healthcare system, but have not as yet implemented comprehensive and integrated management programs to address quality and costs for psychotropic drugs and behavioral health services delivered by general medical providers.**
Specialty mental health services have been managed tightly by managed care systems over

the past two decades. Utilization review techniques and other methods have reduced the percent of total healthcare dollars employers spend on mental healthcare benefits. In fact, private employers experienced a 50% decline in their mental healthcare premiums (not including the cost of psychotropic drugs) during the 1990s: the average cost of private employers' behavioral healthcare premiums dropped from 6.1% of total claims costs in 1988 to 3.2% in 1998.[19] Yet, employers have not adequately managed the cost or quality of behavioral healthcare services delivered in the general medical setting despite the high proportion of patients treated for behavioral disorders in the general medical setting. Further, employers are not receiving good value for their investment in psychotropic drugs.

12. The lack of coordination and integration among managed care vendors of employers (MCOs, MHBOs, EAPs, PBMs, and others) has created significant quality and accountability problems.
Employers can address these problems by improving the design of their health insurance benefit structures, and by requiring their behavioral health vendors and managers to coordinate with one another. Figure 1.0 lists and explains the vendors and employers currently use to manage their health, behavioral health, disability, and employee assistance benefits.

FIGURE 1.0 EMPLOYER-SPONSORED HEALTH AND BEHAVIORAL HEALTH BENEFITS AND MANAGERS

Benefit or Program	Services Offered	Manager or Vendor
Employee Assistance	Prevent intake, referral, and treatment related to mental illness and substance abuse	Human resources department, medical department or other internal manager, EAP vendor
Disability Management	Short-term and long-term disability management services	Internal or external (contracted) disability managers
Health Plan	Primary care, other non-psychiatrist physician care, general inpatient and outpatient care relating to all physical and mental illnesses and substance abuse disorders	Managed care organization (MCO)
Mental Health Plan	Specialty mental health services (in-patient psychiatric hospitalization, psychiatrist visits, psychotherapy, etc) specific to mental illness and substance abuse disorders	Managed behavioral health organization (MBHO) may be "carved-out" (hired directly by an employer) or "carved-in" (hired by an employer via their MCO)
Pharmacy Benefit	Prescription medications (drugs for all medical conditions, psychotropic drugs, etc)	Pharmacy benefit manager (PBM) may be "carved-out" (hired directly by an employer) or "carved-in" (hired by an employer via their MCO)
Wellness Program	Prevention activities relating to mental illness and substance abuse disorders	Medical department or external vendor

I. Recommendations Directed at Health Plan Benefits and Services

The key findings described above guided the development of the *Committee's* recommendations for the delivery of standardized and integrated behavioral health services.

The recommendations featured in this *Guide* are meant to guide employers as they develop their medical and behavioral health benefit plans. Employers are encouraged to add these recommendations to contract language with Managed Care Organizations (MCOs), Managed Behavioral Health Organizations (MBHOs), Pharmacy Benefit Managers (PBMs), and/or Disability carriers as appropriate. Adoption of the recommendations will require employers to change their vendor contract language and to make changes to their benefit structures. Adoption of recommendations regarding best-practice implementation and quality improvement measures will necessitate that employers instruct their MCOs, MBHOs, PBMs to track patient and provider data. Wherever possible, the management vendors should incorporate the recommended standards as a part of their normal provider performance review. Employers should require these vendors to present their findings of these reviews annually.

1. ***Recommendations to Improve the Delivery of Covered Behavioral Healthcare Services in the General Medical Setting***
   - ***a. Documentation and Monitoring*** — Document diagnosis upon initiation of treatment.
   - ***b. Addressing the High-Risk of Co-Morbidity*** — Screen for depression and other common behavioral health conditions among individuals with chronic medical illnesses.
   - ***c. The Importance of Tracking Patient Progress*** — Monitor patient progress with standardized evidence-based instruments. Reimburse patient monitoring as a lab test.
   - ***d. Collaborative Care*** — Use the collaborative care model to address the needs of patients with mental illness and/or substance abuse disorders who are receiving treatment in primary care.

2. ***Recommendations to Improve Collaboration Between Providers in the General Healthcare System and the Specialty Behavioral Healthcare System***
   - ***a. Referrals to the Specialty Behavioral Healthcare System*** — Coordination of care upon referral from primary care to specialty behavioral healthcare.
   - ***b. Improving the Collaboration Between Disease Management Programs, General Medical Care, and Specialty Behavioral Healthcare*** — Employers should require their disease management vendors, as part of their regular practice, to periodically screen all patients enrolled in their respective programs for common behavioral health conditions, and coordinate care with other providers as indicated.

3. ***Recommendations to Improve Benefit Design for Behavioral Health Screening and Treatment Services***
   a. ***Equalizing Benefits Structures*** — Equalize medical and behavioral health benefit structures
   b. ***Reimbursement for Non-Psychiatrist Physicians*** — Reimburse primary care and other non-psychiatrist physicians for screening, assessing, and diagnosing mental illness and substance abuse disorders. [Rules and policies regarding the payment of non-psychiatrist physicians (e.g., primary care physicians) for the treatment of mental illness and substance abuse disorders should be well publicized to primary care physicians, other non-mental health providers, and their clinical/business administrators.]

4. ***Recommendations to Improve the Accuracy and Quality of Prescribing Psychotropic Medications in the General Medical and Specialty Behavioral Healthcare System***
   a. ***Adoption of a national best-practice guideline for the prescribing and monitoring of psychiatric drug interventions*** — Require MCOs, MBHOs, and PBMs to adopt a national best-practice guideline for the prescribing and monitoring of psychiatric drug interventions.
   b. ***Annual assessment of provider performance in relation to the nationally accepted standard best-practice guideline chosen*** — Require MCOs, MBHOs, and PBMs to annually assess their provider's performance in relation to the nationally accepted standard best-practice guideline they have chosen (4a). [Employers should also require that their healthcare managers (i.e. MCOs, MBHOs, and PBMs) to provide them with a summary of the data collected, problems that were identified, and the performance plan improvement to address these problems, annually.]
   c. ***Periodic Review of Formulary*** — Periodically review the formulary and make adjustments as necessary based on information garnered from the assessment suggested in 4b.

5. ***Recommendations to Improve Behavioral Healthcare Services for Individuals with Serious Mental Illness***
   a. ***Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)*** — Provide coverage for evidence-based treatment modalities for seriously mentally ill children and adults. Such evidence-based modalities include:
      - Targeted clinical case management services;
      - Assertive community treatment (ACT) programs;
      - Therapeutic nursery services; and
      - Therapeutic group home services.

b. ***Providers of Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)*** — Direct MCOs and MBHOs to add providers that can deliver the evidence-based treatment modalities described in 5a to their networks.

c. ***Annual Review of Behavioral Health Treatment Modalities*** — Direct MCOs and/or MBHOs to annually review behavioral health treatment modalities and make recommendations about whether new treatment modalities should be added to employers' benefit structures.

II. Recommendations Directed at Disability Management Vendors and Services

6. ***Recommendations to Improve Employer Management of Behavioral Health Disorders that Qualify for Short- and/or Long-Term Disability Benefits***

a. Review short-term and long-term disability management programs and instruct vendors to actively manage all behavioral health disability claims.

- Involve a behavioral health specialist in certification of psychiatric disability and treatment planning.
- Involve a behavioral health specialist in the review of the treatment plan.
- Refer employees on disability for a psychiatric condition to EAP for return-to-work assistance.

III. Recommendations to Improve Employee Assistance Program Services

7. ***Recommendations to Improve the Structure of Employee Assistance Programs (EAPs)***

a. Reduce redundancies between EAPs and health plans by re-structuring EAPs. EAPs should not duplicate services offered through the health plan (MCOs and MBHOs), but should be re-structured, if necessary, to provide the following functions:

- Support management in addressing issues of productivity and absenteeism that may be caused by psychosocial problems.
- Assist in the design and development of a structured program to deliver health promotion and healthcare education tools that significantly affect employee and beneficiary health and productivity and lead the effort to deliver behavioral healthcare education programs.
- Functionally coordinate with other health services including health plan, disability management, and health promotion.

b. Based on an analysis of current EAP services, the NCESBHS found that an important function that EAPs provide is assessment and short-term counseling for individuals at risk of mental illness and substance abuse disorders and those with problems of daily living (e.g., divorce counseling, grief processes). In the restructuring of EAP, as recommended in 7a, it is essential that these services be retained and provided by an EAP or other entity.

c. Conduct periodic organizational assessments to evaluate the effects of work organization on employee health status, productivity, and job satisfaction.

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A note on sources:
References in color are non-federal sources that were not peer-reviewed.

PART I

Center for Prevention and Health Services

National Business Group on Health

Major Trends in the Epidemiology, Treatment, and Cost of Behavioral Healthcare in the United States

- Epidemiology of Behavioral Health Disorders Among Children, Adolescents, and Adults in the United States
- The Treatment of Behavioral Health Disorders
- The Cost of Treatment for Behavioral Health Disorders
- The Workplace Costs of Behavioral Health Disorders

1. The Epidemiology of Behavioral Health Disorders Among Children, Adolescents, and Adults in the United States

Mental Illness

It is estimated that in any given year, one in five adults, will experience a diagnosable mental illness or substance abuse disorder. About half of this group, (approximately 9.2% of adults) experience a **Serious Mental Illness (SMI)**. A SMI is defined as a diagnosable mental, behavioral, or emotional disorder that meets diagnostic criteria specified in the DSM-IV and causes functional impairment that limits one or more major life activities.[1] Examples of Serious Mental Illnesses include major depression, bipolar depression, generalized anxiety disorder, and other disorders. *Substance abuse disorders are not included in the definition of SMI.*

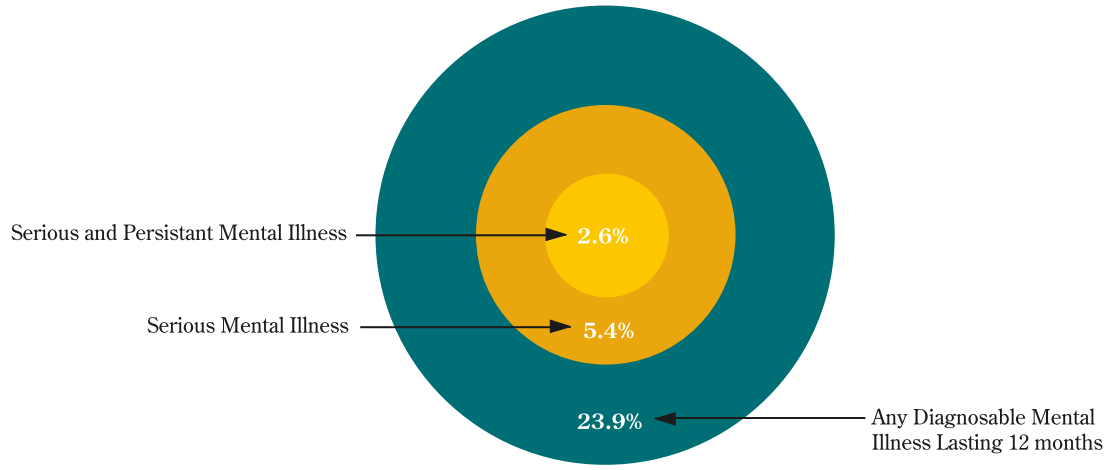
Adults with the most severe types of mental illness and who have the most severe functional limitations are said to have **Serious and Persistent Mental Illness (SPMI)**. Children and adolescents with mental health problems that are so severe and long lasting that they seriously interfere with functioning in family, school, community, or other major life activities are said to have **Serious Emotional Disturbances (SEDs)**. Children and adolescents with less severe mental health problems are said to have **emotional disturbances or mental health problems.**

A Note on Statistics:

The statistics highlighted in this document usually refer to the general term, mental illness and substance abuse disorders. This definition includes all adults with a diagnosable metal illness or substance abuse disorder including (but not limited to) adults with SMIs or SPMIs. Statistics that specifically refer to SMI, SPMI, SED, or substance abuse disorders are noted.

SMI rates differ by age, gender, race, and socioeconomic status. SMI rates are highest for young adults age 18-25 (13.9%) and are lowest for adults age 50 or above (5.9%).[1] In all age brackets, women experience higher rates of SMI than do men. Individuals with less education experience higher rates of SMI; while 6.5% of college graduates suffered form a SMI in 2003, 9.6-11.3% of adults who did not complete high school suffered from an SMI.[1] Unemployed persons also experience a higher burden of SMI; 15.2% of unemployed adults suffered from a SMI in 2003 compared to only 8.2% of adults who were employed full-time.[1] Mental illness and substance abuse disorders are more common among blue-collar workers (27%) than white-collar workers (21%).[1]

FIGURE: 2.0 ESTIMATED PREVALENCE OF MENTAL ILLNESS AMONG ADULTS IN THE UNITED STATES, 1999.



Source: Department of Health and Human Services. *Federal Register*, 1999; 64(121): 33897.

Substance Abuse

Substance abuse refers to the abuse of alcohol, illicit drugs, or both. In 2004, approximately 22.5 million Americans age 12 and above experienced a substance abuse or substance dependence disorder.[2]

Co-Occurring Disorders

Mental illness and substance abuse are intertwined. In 2003, 21.3% of adults with a SMI were dependent on or abused alcohol or drugs (compared to only 7.9% of adults without a SMI). Similarly, 21.6% of adults with a substance abuse disorder also had an SMI (compared to only 8.0% without a substance abuse disorder).[1] Researchers estimate that 4.2 million American adults met criteria for both a SMI and a substance abuse disorder during 2002- 2003.[1]

Lifetime Prevalence

The estimated lifetime prevalence for mental illness and substance abuse disorders is high. At some point during his or her lifetime, the average American has a 46% chance of developing one or more mental illness or substance abuse disorders: 29% of Americans will suffer an anxiety disorder, 25% will suffer an impulse-control disorder, 21% will suffer a mood disorder (e.g., depression), and 15% will suffer a substance-abuse disorder.[3]

Mental Illness and Substance Abuse in the "Working Population"

In any given year, 39 million adults age 18-54 (the "working" population) experience a mental illness and/or substance abuse disorder.[4] In the working population, alcohol abuse/dependence and major depression are the most prevalent behavioral health problems. In 2003, 8.2% of full-time employed adults experienced a mental illness.[2] In 2004, 10.5% of full-time employed adults and 11.9% of part-time employed adults experienced a substance abuse or substance dependence disorder.[2] Contrary to popular belief, most individuals with mental illness and

substance abuse disorders work. Approximately 90% of adults classified as having a substance abuse or dependence disorder and 72% of individuals with a mental illness work.[2]

FIGURE 2.1: RATES OF MENTAL ILLNESS AND SUBSTANCE ABUSE BY EMPLOYMENT STATUS

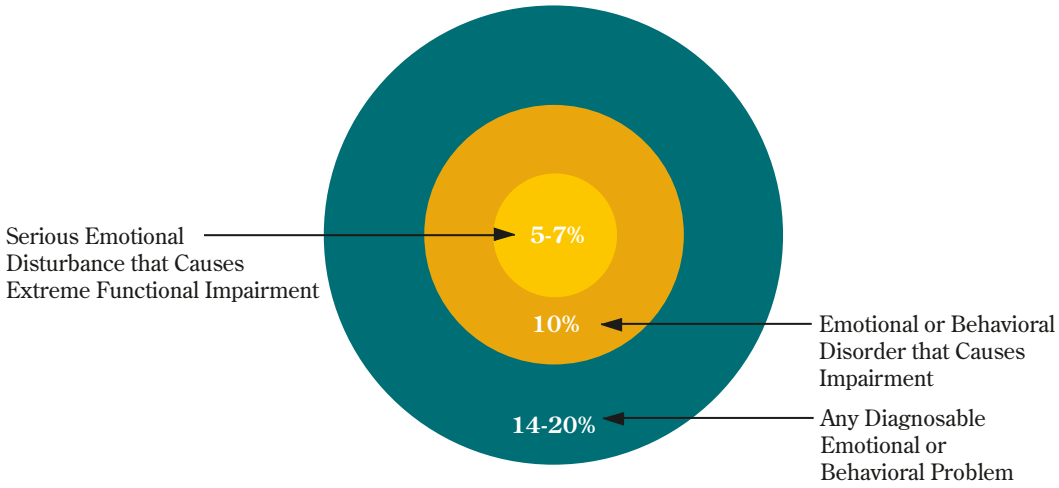
Population	Percent with a SMI	Percent with a Substance Abuse Disorder
All adults in the United States	9.2%	
Adults employed full-time	8.2%	10.5%
Adults employed part-time		11.9%
Unemployed Adults	15.2%	

Source: Substance Abuse and Mental Health Services Administration. *Overview of findings from the 2004 National Survey of Drug Use and Health* (Office of Applied Studies). DHHS Publication No. SMA 05-4061. Rockville, MD: Center for Mental Health Services, Department of Health and Human Services; 2005.

Emotional/Behavioral Disorders and Substance Abuse Among Children and Adolescents

Research from epidemiological catchment studies suggest that between 14%-20% of children and adolescents, about one in every five, have a diagnosable emotional or behavioral disorder.[5] An estimated 10% of children have a emotional or behavioral disorder severe enough to cause some form of impairment[6] and 5-7% of children have a severe emotional disturbance (SED) that causes extreme functional impairment.[5]

FIGURE 2.2: ESTIMATED PREVALENCE OF EMOTIONAL/BEHAVIORAL DISTURBANCES AMONG CHILDREN AND ADOLESCENTS IN THE UNITED STATES, 1999.



Sources: RAND. Mental healthcare for youth: Who get is? Who pays? Where does the money go? Publication No RB-4541. RAND. Santa Monica, CA; 2001; U.S Department of Health and Human Services. *Mental Health: A Report of the Surgeon General – Executive Summary*. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999.

Children and adolescents are affected by many of the same behavioral health problems that affect adults. Anxiety is the most common emotional/behavioral disorder among children. Approximately 13% of 9-17 year old children and adolescents have an anxiety disorder.[7] Attention Deficit/Hyperactivity Disorder (ADHD) is another common emotional/behavioral disorder among school-age children. ADHD is estimated to affect 4.8% of children ages 5-9, 7.9% of children ages 10-12, and 7.6% of adolescents age 13 and older.[8] The Centers for Disease Control and Prevention (CDC) estimates that in 2003, 2.5 million youth ages 4-17 received medication treatment for the ADD/ADHD.[9] Other common disorders that affect children and adolescents include depression and eating disorders.

- Approximately 2% of children and 8% of adolescents suffer from major depression.[10]
- Lifetime eating-disorder prevalence rates for females average 0.5-3.7% for anorexia nervosa, 1.1-4.2% for bulimia and 2-5% for binge-eating disorder.[11]

Substance use and substance abuse is also a concern among school-age children and adolescents. For example:

- Approximately 11.2% of all youths aged 12-17 used illicit drugs at least once during 2003; 7.9% used marijuana, 4% used prescription drugs, 1.3% used inhalants, 1% used hallucinogens, and 0.6% used cocaine. Illicit drug use increases with advancing age during adolescence and young adulthood and then begins to decline during the mid-late 20s. Eighteen to twenty year-olds have the highest rate of illicit drug use (23.3%).[1]
- Approximately 17.7% of youths aged 12-17 self-report alcohol use within the past 30 days; 10.6% report binge drinking and 2.6% report heavy alcohol use.[1] Drinking, binge-drinking, and heavy alcohol use all increase with advancing age during adolescence and young adulthood. For example, while only 0.9% of 12-year-olds report binge-drinking within the past 30 days, 7.1% of 14-year-olds, 18% of 16-year-olds, and 24.5% of 17-year-olds report binge-drinking behavior.[1]

2. The Treatment of Behavioral Health Disorders

The Effectiveness of Treatment for Behavioral Health Disorders

Treatment modalities for mental illness and substance abuse disorders are well-established and for most disorders there is a rage of treatment methods with proven efficacy.[5] Most treatment methods fall into one of two categories: pharmacological methods (e.g., psychotropic medications) and psychosocial methods (e.g., psychotherapy, intensive outpatient for substance abuse, etc). Current research suggests that the most effective treatments for mental illness combine appropriate pharmacological methods with psychosocial methods.[5]

Mental illness and substance abuse disorders, particularly depression and other common problems, are treatable conditions. With appropriate diagnosis, treatment, and monitoring, approximately 80% of individuals with depression will recover fully.[12]

Without adequate treatment, mental illness and substance abuse disorders can become disabling and even life-threatening. Suicide is the leading cause of violent death worldwide[13] and the majority of people who attempt and commit suicide suffer from one or more mental illness or substance abuse disorders. In 2001, suicide took the lives of 30,622 people in the United States, nearly one every 18 minutes.[14] Approximately 500,000 people age 18-54 attempt

suicide annually[4] and every day over 1,900 people seek treatment in hospital emergency departments for self-inflicted injuries.[15]

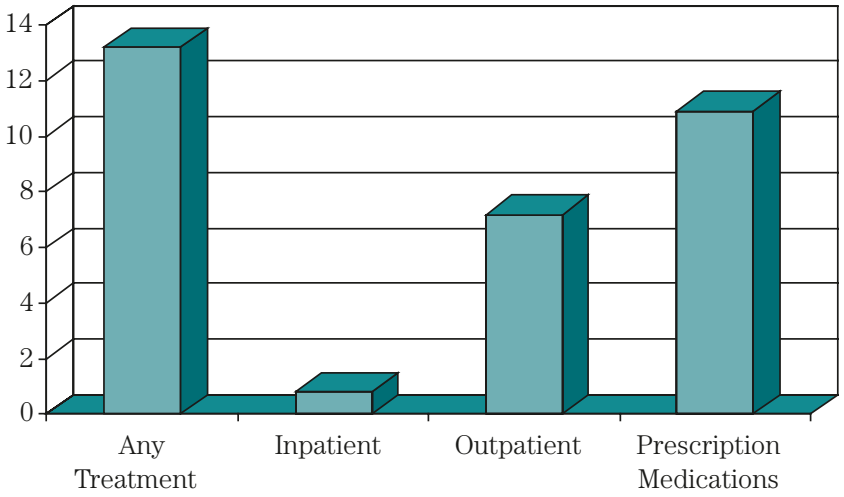
Treatment Patterns

The *National Co-morbidity Survey Replication (NCS-R)*, conducted during 2001-2003, found that:

- 17.9% of all individuals in the United States received treatment for a mental health or substance abuse disorder in the year prior to their interview.[16]
- 41.4% of individuals with an anxiety, mood, impulse control, or substance abuse disorder that met the diagnostic criteria set forth in the DSM-IV and lasted at least 12 months received some form of treatment for their condition during the year prior to their interview. Of these individuals:[16]
  - 22.8% were treated by a general medical provider such as a primary care physician;
  - 16.0% were treated by a non-psychiatrist mental health provider;
  - 12.3% were treated by a psychiatrist;
  - 8.1% were treated by a human services provider; and
  - 6.8% were treated by a complementary and alternative medicine provider.[16]

Data from the *National Co-morbidity Survey (NCS)* and its follow-up, the *National Co-morbidity Survey Replication (NCS-R)*, indicate that the percentage of adults who receive treatment for a mental health or substance abuse disorders is increasing; 13.3% of the population received treatment in 1990 compared to 17.9% in 2003.[16] This represents a 34.5% increase in the number of people with a mental illness or substance abuse disorder who received treatment for their condition. The percentage of adolescents who received treatment for a mental health or emotional problem also increased from an estimated 19.3% in 2002 to 22.5% in 2004.[2]

FIGURE 2.3 PERCENT OF ADULTS IN THE UNITED STATES WHO RECEIVED TREATMENT FOR A MENTAL HEALTH PROBLEM DURING 2003, BY TREATMENT TYPE



Source: Substance Abuse and Mental Health Services Administration. Overview of findings from the 2004 National Survey of Drug Use and Health (Office of Applied Studies), Rockville, MD; Substance Abuse and Mental Health Services Administration; 2005.

Sources of Care

Adults seek help for mental illness and substance abuse from many different sources, including: lay people such as family and friends, or pastors; and professionals such as EAP therapists, social workers, therapists, psychologists, psychiatrists, or other mental health specialists, and non-psychiatrist physicians.

Psychiatrists and psychologists, who were once the mainstay of mental health providers, currently make up less than half of the mental health professionals in the United States. In 2002, there were 40,867 clinically active psychiatrists in the United States and over 88,500 licensed psychologists.[17] The remainder of mental health service providers are master's level professionals such as social workers (clinical social workers and others); counselors (e.g., substance abuse, educational, vocational, school, rehabilitation, etc); and marriage and family therapists.[17,18]

Behavioral healthcare is also delivered in the general healthcare setting by primary care providers (e.g., family doctors, pediatricians, OB/GYN) and medical specialists such as cardiologists, endocrinologists, and oncologists.

Increasing Role of Primary Care Physicians in the Provision of Treatment Services for Behavioral Health Disorders

Primary care physicians (PCPs) have played an increasingly prominent role in the treatment of mental illness since the advent of better-tolerated depression and anxiety medications such as selective-serotonin reuptake inhibitors (SSRIs). Half (51.6%) of patients treated for major depression are seen in the general medical sector and are cared for exclusively by primary care or other non-psychiatrist physicians.[19] It is also estimated that 67% of psychopharmacological drugs are prescribed by primary care physicians.[5] The ability of primary care physicians to treat mental illness with psychotropic medications has undoubtedly increased access to mental healthcare. Yet, when these treatment interventions become the sole or predominant treatment modality for people with behavioral health disorders, a number of problems emerge. Quality problems will be discussed in further detail in *Part III: The Current State of Employer-Sponsored Behavioral Health Services.*

> *A significant percentage of patients in primary care show signs of depression, yet up to half go undetected and untreated. This is especially problematic for women, people with a family history of depression…and those with chronic disease, all of whom are at increased risk for depression.*
>
> — The President's New Freedom Commission on Mental Health

> *While primary care providers appear positioned to play a fundamental role in addressing mental illnesses, there are persistent problems in the areas of identification, treatment, and referral.*
>
> — The President's New Freedom Commission on Mental Health

General medical providers, especially primary care physicians, will continue to play an important role in behavioral healthcare treatment. Interventions and models of care such as collaborative care have been developed to support primary care physician's ability to effectively screen, treat, and monitor patients with behavioral health disorders.

Collaborative Care: A Cost-Effective Primary Care Treatment Modality

Successful interventions to improve care for depression have a number of common features, commonly referred to as "collaborative care." The collaborative care model focuses on treatment in general medical settings (vs. specialty behavioral healthcare settings) for most patients. Collaborative care includes and combines several quality improvement strategies, such as screening, case identification, and proactive tracking of clinical (e.g., depression) outcomes, clinical practice guidelines and provider training, support of primary care providers treating depression by a depression care manager (e.g., a nurse, clinical social worker, or other trained staff), and collaboration with a behavioral health specialist (e.g., a psychologist or a psychiatrist).

While the details vary, collaborative care interventions have two key elements. The first is *case management* by a nurse, social worker, or other trained staff, to facilitate screening, coordinate an initial treatment plan and patient education, arrange follow up care, monitor progress, and modify treatment if necessary. Case management can be provided in the clinic and/or by telephone. The second is consultation between the case manager, the primary care provider, and a consulting psychiatrist, in which the psychiatrist advises the primary care treatment team about their caseload of depressed patients. This consultation is intended to maximize the cost-effectiveness of collaborative care, by facilitating a process described as "stepped care," where the treatment algorithm starts with relatively low-intensity interventions such as antidepressant medication prescribed by the primary care provider and telephone case management, with patients who fail to respond being shifted to progressively more intensive approaches including specialty behavioral healthcare.

More than ten large trials, in a wide range of settings, have demonstrated the feasibility of improving depression treatment and outcomes, relative to usual care.[20,21,22] The documented benefits of collaborative depression care include:

- Higher rates of evidence-based depression treatment (i.e., antidepressant medication and/or psychotherapy)
- Better medication adherence/compliance
- Reduction in depression symptoms, and earlier recovery from depression
- Improved quality of life
- Higher satisfaction with care
- Improved physical functioning
- Increased labor supply

Collaborative care has typically been found to increase direct healthcare costs slightly, relative to usual care, mainly by increasing the use of evidence-based depression treatment. *However, this investment yields substantial improvements in patients' health status and functioning, so that collaborative care is more cost-effective than usual care for depression and has very favorable cost-effectiveness compared with other accepted medical interventions.* For example, the largest trial of collaborative care for depression to date found that the program participants were depression-free for an additional 107 days over two years, relative to usual care, without adding significant increases to healthcare costs.[23]

Treatment Patterns of Children and Adolescents

According to the *2004 National Survey on Drug Use and Health*, 20.6% of youths age 12-17 (5.1 million) received treatment or counseling for an emotional or behavioral problem during 2003.[1]

Youths with emotional disturbances, or substance abuse disorders receive treatment from a variety of professionals including: school counselors, schools psychologists, or teachers (48.0%), and private psychologists, psychiatrists, social workers or therapists (46.1%). Of the 5.1 million youths who received treatment for mental health problems in 2003, 467,000 (9.1%) were hospitalized for their condition.[1] Similar to adults, children and adolescents receive a significant proportion of psychotropic medications from general medical clinicians, primarily primary care providers such as pediatricians.

Antidepressant Use Among Children and Adolescents

Antidepressants, stimulants, and other psychotropic drugs are prescribed to children and adolescents in large numbers. In 1998, 1.6% of children under the age of 12 were given a prescription for an anti-depressant; by 2002 the rate had nearly doubled to 2.4%. Antidepressant use among girls has increased more rapidly than among boys (a 68% increase versus a 34% increase) and the highest rate of antidepressant use (6.4%) among children and adolescents occurs among females ages 15-18.[24] The increasing rate of antidepressant use appears to be driven, in part, by the introduction of better-tolerated selective-serotonin reuptake inhibitors (SSRIs).[24]

Recent research has shown that antidepressants may increase suicidal ideation and behavior in some children and adolescents with major depressive disorder (MDD).[25] The Food and Drug Administration (FDA) has issued a "black box warning" and guidelines for physicians treating children and adolescents for depression, obsessive-compulsive disorder (OCD), and other emotional disturbances/mental illnesses. The FDA guidelines state that:

> All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. Such observation would generally include at least weekly face-to-face contact with the patients or their family members or caregivers during the first four weeks of treatment, then every other week visits for the next four weeks, then at 12 weeks, and as clinically indicated beyond 12 weeks. Additional contact by telephone may be appropriate between face-to-face visits.[25]

The FDA also recommends that physicians counsel families and caregivers about the need to monitor pediatric and adult patients for the emergence of anxiety, irritability, agitation, sudden behavior changes, and other symptoms associated with a clinical worsening of depression and/or an increase in suicidality.[25]

Despite these warnings, psychotropic medications are viewed as an essential treatment option for children and adolescents with depression and other emotional disorders.

Stimulant Use Among Children and Adolescents

The prevalence of ADHD and the number of children with ADHD who are treated with stimulants has increased dramatically since the mid 1980s. Between 1987 and 1997 the rate of outpatient treatment for ADHD among children 0-18 tripled from 0.9 per 100 children to 3.4 per 100 children.[26]

There are multiple treatment modalities for ADHD. The majority (75%) of pediatric patients respond to medication for ADHD in the short term, and many see dramatic improvements in behavior, school attendance, and self-esteem.[26] Several psychotropic drugs are used to treat the symptoms of ADHD. Methylphenidate and amphetamine have the strongest empirical evidence for efficacy. Recent research suggests that the three most common types of treatment for AHDD include stimulant pharmacotherapy (42%), a combination of psychotherapy and medication (32.1%), and psychotherapy or counseling but no medication (10.8%).[27] Approximately 15.1% of children with a diagnosis of ADHD do not receive any type of formal treatment.[27]

The most effective type of treatment for ADHD appears to the combination of medication with some form of psychotherapy or formal counseling.[27] Emerging interventions, such as neurofeedback, may provide an effective alternative to medication.[28] Some researchers and advocates believe that medication is overused in the pediatric ADHD population and that psychotherapy alone is an effective treatment method for most children.

Approximately one-quarter to one-half of children with ADHD also have a co-morbid mental illness[27] or other non-ADHD behavioral health disorders.[29] Depression and OCD appear to be the most common types of co-morbid illness in the pediatric ADHD population, with depression affecting an estimated 31.6% of all children with ADHD.[30] Oppositional defiant disorder (ODD) and substance abuse/ drug dependency (SADD) also occur at higher rates among children and adolescents with ADHD than those without ADHD.[29] A recent study of pediatric ADHD patients in a commercial HMO population found that 28.7% of children with identified ADHD had at least one other behavioral health disorder.[29]

Children and adolescents with ADHD often have poor medication compliance. During a given year the average patient with ADHD refills his/her prescription six times, but these refills are often late, meaning that there were many skipped doses. Researchers estimate that only 16% of children with ADHD are compliant with their medication regiment for more than two months in a given year.[30]

Many parents are concerned about the increasing prevalence of ADHD and the increasing use of stimulants to treat ADHD and are searching for non-drug treatments. One survey found that 55% of parents whose children were diagnosed with ADHD were reluctant to begin their child on stimulants or other medications based on information they had heard/read in the lay press.[31] And 38% of these parents believed that too many children in the United States were on medication for ADHD.[31]

3. The Cost of Treatment for Behavioral Health Disorders

Mental illness and substance abuse disorders, as a group, are considered to be one of the 15 most expensive health conditions in the United States.[32] These illnesses impose costs on individuals and families, local communities and States, the federal government, and employers. In 2001, mental health and substance abuse treatment costs totaled $104 billion ($85 billion (82%) was spent on mental health treatment and $18 billion (18%) was spent on substance abuse treatment).[1] The cost of behavioral healthcare represents 7.6% of the total healthcare spending in the United States (estimated at $1.4 trillion in 2001).[33] This figure is based on expenditures for all payers, not just private payers, and does not represent the cost of behavioral healthcare treatment delivered by general medical clinicians or the cost of psychotropic drugs.

Treatment Cost Profiles

As noted previously, the providers, sites, and methods of treatment for mental illness have changed over the past three decades. Up until the 1990s, the bulk of treatment costs were facility charges (for inpatient and outpatient hospital care) and provider charges (for psychotherapy and other psychosocial services). With the advent of newer and better-tolerated antidepressants and anti-psychotics, psychotropic medications became a prominent method of treatment and a major expense.

During the mid 1990s, inpatient hospitalization rates fell for the privately insured; fewer individuals were hospitalized (-0.8%) and those who were hospitalized had shorter stays (19.9% fewer days per year per patient). As a result, overall hospitalization costs decreased by 30.4%. Outpatient costs also declined during this period.[34] The same trend is visible in the privately insured adolescent population. Between 1997-2000 the rate of inpatient hospitalization for adolescents decreased by 23.7% and the length of stay for hospitalized adolescents was reduced by 20.0%. Similarly, there was also a reduction in adolescent outpatient psychiatric visits (-11.3%).[35]

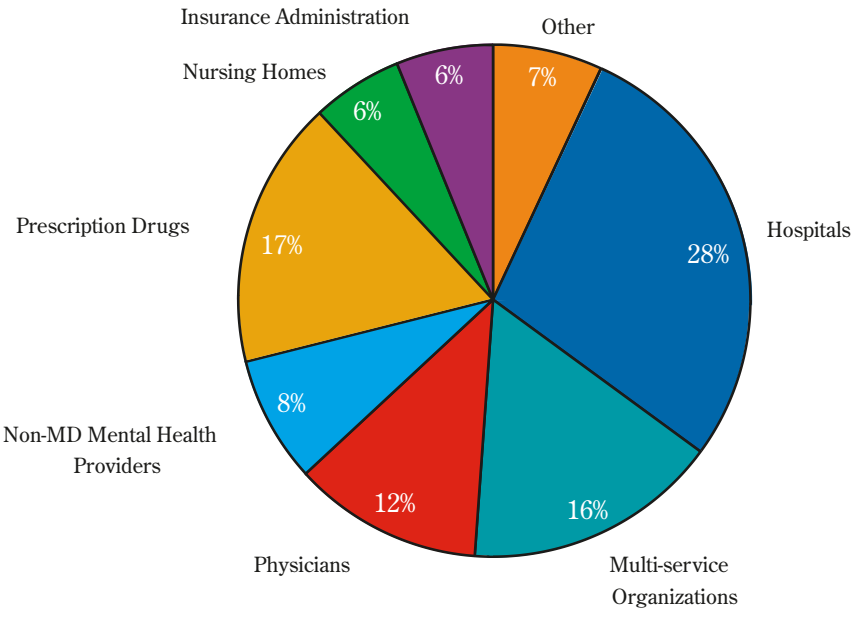
Despite the decrease in inpatient hospitalization rates, overall utilization of behavioral healthcare services has increased. The percentage of adults who received treatment for a mental illness or substance abuse disorder increased 34.5% from the early 1990s to 2003.[16] The percentage of adolescents who received treatment for a mental health or emotional problem also increased from an estimated 19.3% in 2002 to 22.5% in 2004.[2] Researchers note that this increase is primarily explained by an increased use of prescription drugs.[35,36]

FIGURE 2.4: TOTAL COST OF MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES, BY SERVICE AND PROVIDER TYPE, 2001

	Total	% of MH/SA Treatment Costs
Hospitals	$29.1 billion	28%
Retail prescription drugs	$17.9 billion	17%
Multi-service MH/SA organizations (e.g. mental health clinics)	$16.4 billion	16%
Physicians (psychiatrists and other physicians)	$12.1 billion	12%
Psychologists, social workers, and other non MD mental health professionals	$8.1 billion	8%
Insurance administration	$6.4 billion	6%
Nursing homes	$5.8 billion	6%
Other	$8.2 billion	7%
Total	$104 billion	100%

Source: Mark TL. Coffey RM. Vandivort-Warren R. Harwood HJ. King EC. US spending for mental health and substance abuse treatment, 1991-2001. *Health Affairs*, 2005; W5: 133-142.

FIGURE 2.5 PROPORTION OF TOTAL MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT COSTS BY SERVICE TYPE AND PROVIDER TYPE, 2001



Source: Mark TL. Coffey RM. Vandivort-Warren R. Harwood HJ. King EC. US spending for mental health and substance abuse treatment, 1991-2001. *Health Affairs*, 2005; W5: 133-142.

Impact of the Shifting Methods of Treatment on Cost: The Role of Prescription Medications in the Treatment of Mental Illness

In 2001, 8.1% of the United States population (including the privately insured, Medicaid, Medicare, and the uninsured) used prescription medication for the treatment of a mental illness or substance abuse disorder with mean spending estimated at $639 per user.[36] In 2001, 6.7% of the privately insured population used mental health or substance abuse services with mean spending estimated at $617 per user.[36]

The increased number of individuals using prescription medications for the treatment of a mental illness and/or substance abuse disorder has had a dramatic effect on the cost profile of treatment. In 1987, psychotropic medications were responsible for 7.7% of all behavioral healthcare spending in the United States, but by 2001, psychotropic drug spending had jumped to 21.0% of total behavioral healthcare spending.[37] Further, psychotropic drugs have become an increasingly large proportion of total drug spending. For example, during the 1990s (1992-1997) spending on psychotropic drugs grew at twice the rate of drug spending overall.[37]

FIGURE 2.6: NATIONAL EXPENDITURES ON PSYCHOTROPIC DRUGS FOR MENTAL HEALTHCARE 1987-2001.

	1987	1992	1997	2001
Nominal spending	$2.77 billion	$3.83 billion	$9.04 billion	$17.83 billion
Percentage of total mental health spending	7.7%	7.2%	12.8%	21.0%

Source: Frank G. Conti RM. Goldman HH. Mental health policy and psychotropic drugs. *The Millbank Quarterly*. 2005; 83(2): 271-298.

As the proportion of dollars spent on prescription drugs increased during the 1990s, the proportion of dollars spent on facilities, particularly inpatient hospitalization, decreased.

The availability of prescription medications as a method of treatment has improved the lives of many individuals with mental illness and substance abuse disorders. Individuals who in years past would have been confined to hospitals or institutions are now able to effectively manage their symptoms with medications and live in the community. Other individuals have found more immediate or effective relief from symptoms using prescription medication compared to other types of treatment. And still others have found that prescription medications improve the effectiveness of psychotherapy or other types of treatment. Yet, the increasing reliance on prescription medication has some scientists, doctors, and researchers worried. In 2001, 34% of mental health and substance abuse service users relied solely on prescription medications for treatment, compared to only 26% in 1996.[36] This represents a 30.7% increase in the number of behavioral healthcare patients relying on medication as a sole form of treatment.

While there are likely many factors responsible for the increasing use of medication as a sole method of treatment, benefit plan structures are one likely cause. Frank, Conti, and Goldman note that:

> The mental health delivery system has devised rules for managing care that are not economically neutral with respect to therapeutic choices. Prescription drug coverage for psychotropic drugs is at parity with other types of drugs. Thus, drug coverage is typically generous relative to, for example, psychotherapy. Those people with private insurance plans frequently must pay 50% of their psychotherapy. Compared with the $10 to $20 co-payments for drugs, these prices encourage the use of prescription medications.[14]

Economic Costs of Behavioral Health Disorders Among Children and Adolescents
The cost of treating children and adolescents (ages 1-17) for behavior disorders and emotional disturbances is estimated at $11.8 billion annually.[6] Roughly half of this cost ($6.9 billion) is for the treatment of adolescents (ages 13-18).

The cost profile of child and adolescent treatment is much different than the cost profile of the adult population struggling with behavioral health disorders; children spend more on outpatient care, but substantially less on medication than do adults. Children and adolescents, like adults, frequently see primary care physicians (PCPs) for mental health problems. It is estimated that one-third of all child behavioral healthcare visits are to a PCP.[6]

In addition to the direct costs associated with behavioral and emotional disorders in children, there are also indirect costs such as time away from work for parents caring for children with behavioral health problems and lost school days.

Increased Medical Costs for Persons with Chronic Medical Conditions and Co-Morbid Behavioral Health Conditions
Many individuals with chronic medical conditions are at increased risk of mental illness and substance abuse disorders, particularly depression. For example, depression is clinically relevant in nearly one of every three individuals with diabetes.[38] Individuals with co-morbid physical and behavioral health problems are often high-risk and high-cost cases. Co-morbid depression increases healthcare use and expenditures among individuals with chronic disease, even when other variables such as age, gender, and other illnesses are accounted for.[39] Patients with mental illness and substance abuse disorders are often less responsive to treatment for their medical condition. For example, depressed patients are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.[40]

Individuals with diabetes and co-morbid depression have healthcare costs that are 4.5 times higher than individuals with diabetes without co-morbid depression.[4]

Depression can also put individuals with chronic illnesses at risk for other health problems. For example, depression is an independent risk factor for neck and low back pain. Individuals with severe depression report neck and low back pain four times as often as those with no or mild depression. And individuals with both back pain and depression use twice as many sick days and incur twice the healthcare costs as those with either problem separately.[42]

Interrelationships Between High-Cost Chronic Medical Conditions and Co-Morbid Behavioral Health Conditions

- The presence of type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28.5% of diabetic patients meet criteria for clinical depression.[39] There are also correlations between heart disease and depression.
- Individuals with major depression average twice as many visits to their primary care doctor than do non-depressed patients.[43]
- Approximately one in six patients treated for a heart attack experiences major depression soon after their heart attack and at least one in three patients have significant symptoms of depression.[40]
- Cardiac patients with depression suffer a reduced quality of life and functionality due to their condition, even when medical indicators such as treadmill tests suggest that they are no less healthy than other heart attack survivors.[44]

Cost-Effectiveness of Treatment

Treatment does not only improve quality of life for the patient, it can also avert some of the direct and indirect costs associated with behavioral health problems and disorders.

Effective treatment for depression has the potential to save both direct and indirect costs. For example, a randomized trial that examined the effect of primary care depression management (i.e. collaborative care program model) on employer costs found that consistently-employed patients who participated in an enhanced depression management program had 8.2% greater productivity and 28.4% less absenteeism over two years that did employees who received "usual care." The reduction in absenteeism and the increase in productivity had an estimated annual value of $2601 per full-time equivalent employee ($1,982 for improved productivity and $619 for reduced absenteeism).[45]

Cost-effective treatments exist for most [behavioral] disorders and, if correctly applied, could enable most of those affected to become functioning members of society.

— The World Health Organization

Mental Healthcare and Substance Abuse Treatment Payers

The direct cost of behavioral healthcare is shared among state and local payers (Medicaid and others), federal payers (Medicaid and Medicare), private insurance, and individual out-of-pocket costs. Federal and state governments pay a higher proportion of the behavioral healthcare costs than do private insurers.[33]

Public Payers

State and local governments (through Medicaid and other local services) pay for 37% of all behavioral health treatment services in the United States. The federal government (through Medicaid, Medicare, Veteran's care, and other grants) pays for 28% of all behavioral health treatment services in the United States.[1] Medicaid is the largest single payer for behavioral health treatment services. In 2001, Medicaid paid for 26% of all treatment services.[1] Medicaid is jointly funded by the federal government and by state and local governments. Medicare, funded entirely by the federal government, paid for 7% of the total cost of treatment services

in 2001.[33] Other federal payers such as the Veterans Affairs Bureau and federal block grants paid for approximately 6% of services in 2001.[33] These cost figures do not include the money that federal and state governments spend on mental health and substance abuse treatment research and other services such as costs of incarceration related to mental illness or substance abuse.

Private Payers

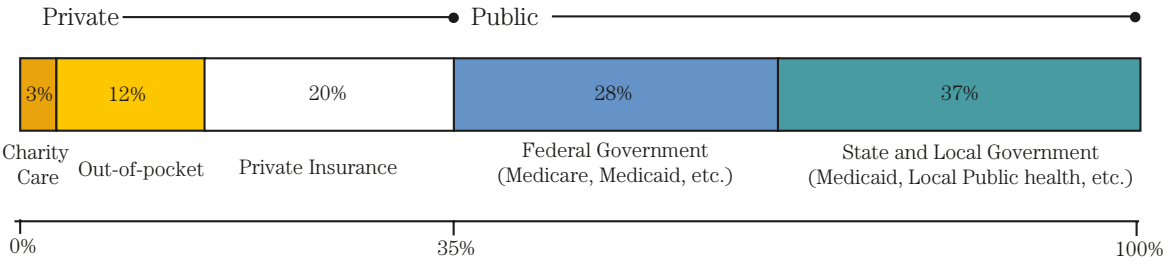
Private payers covered 35% of the total cost of behavioral health treatment services in 2001; private and employer-sponsored health insurance paid for 20%, patients — through out-of-pocket costs — paid for 12%, and 3% was paid by charity care.[33]

The proportion of behavioral healthcare expenses paid by patients is high. Privately insured individuals pay out-of-pocket for 34% of the cost of their ambulatory care and 30% of the cost of prescription medications.[36] Privately insured individuals' out-of-pocket costs for behavioral healthcare are usually much higher than their out-of-pocket costs for general healthcare. For example, it is common for specialty behavioral health service co-pays (required to access care from psychiatrists, counselors, social workers, and other behavioral healthcare specialist) to be double, triple, or even quadruple the co-pays for primary care services.

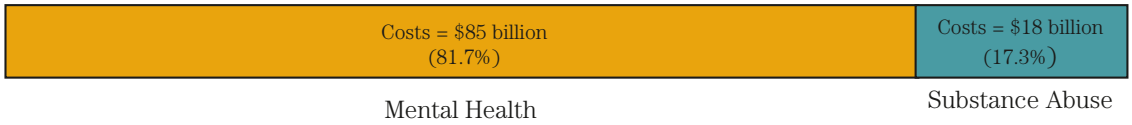
The average privately insured individual treated for a mental illness spends 3% of his/her total household income on behavioral healthcare services. And 5.2% of privately insured individuals spend 20% of their total household income on behavioral healthcare services.[46]

In 2001, Ringel and Sturm conducted a survey of privately insured individuals with mental illnesses to assess the out-of-pocket costs associated with behavioral healthcare. They found that the average privately insured individual in treatment for a mental illness spent 3% of his/her total household income on behavioral healthcare services each year, and paid for 30% of his/her total treatment costs. Some individuals had much higher expenses; 5.2% of individuals in treatment spent 20% of their total household income on behavioral healthcare and 25% of privately insured individuals paid for 50% of their treatment costs.[46]

Breakdown: Who s Paying What for Mental Health and Substance Abuse Treatment? 2001



Comparison of U.S. Spending on Treatment: Mental Health vs. Substance Abuse, 2001



4. The Workplace Costs of Behavioral Health Disorders

The workplace costs of mental illness and substance abuse disorders, otherwise known as indirect costs, include metrics such as excess turnover, lost productivity (also known as work loss, work impairment, or presenteeism), absenteeism (incidental absences, etc), and disability (short- and long-term).

Unlike other medical conditions such as heart disease or diabetes, the indirect costs associated with mental illness and substance abuse disorders commonly meet or exceed the direct treatment costs. In fact, some researchers estimate that the indirect costs of behavioral health disorders account for nearly 75% of the total costs of mental illness to employers.[47] Estimates of the total workplace costs of mental illness and substance abuse disorders range from a low estimate of $79 billion per year[5] to a high of $105 billion per year (both figures based on 1990 dollars).[48]

> *The burden of mental illness on health and productivity in the United States and throughout the world has long been profoundly underestimated.*
>
> — US Surgeon General's Report on Mental Health

Behavioral Health and Productivity: The Overlooked Link

Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis.[49] About half of people with mental illnesses such as major depression and/or anxiety disorders suffer work loss or work impairment. Work loss is a general term that includes incidental absences and short-term disability. Work impairment is a general term referring to productivity decline, presenteeism, or "work cutback." Kessler et al. studied work loss and work impairment due to chronic

medical conditions and found that individuals with mental illness reported losing between 4.3-5.5 days of productive work during the 30 days prior to their interview.[49] And other researchers have found that employees suffering from depression are four to five times more likely to experience work-related problems than either healthy employees or employees with chronic physical illnesses such as diabetes and heart disease.[50]

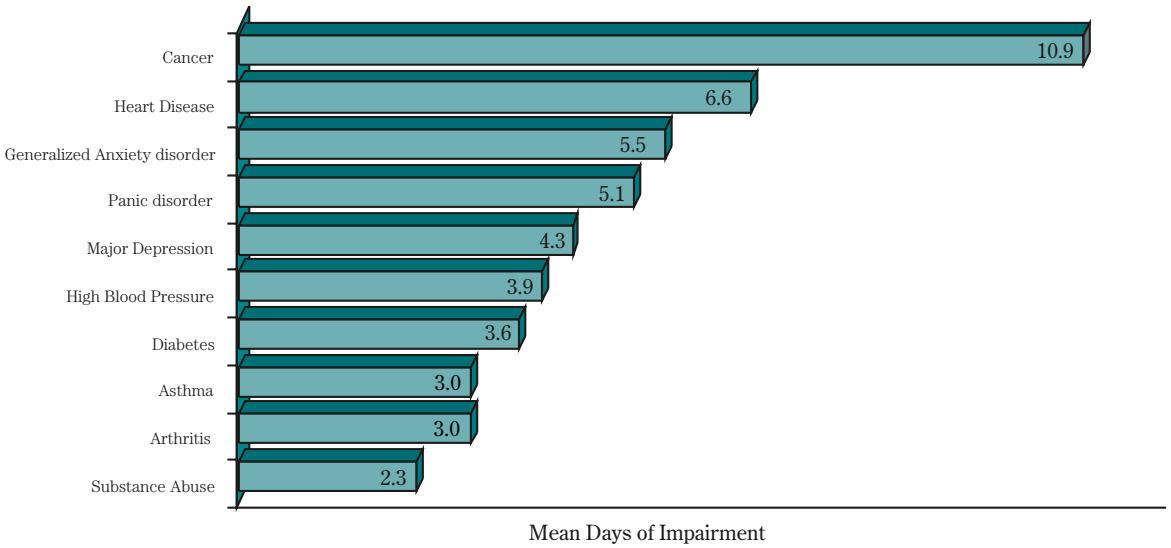
Work Loss

Researchers estimate that 36 million productive workdays are lost each year in the United States due to behavioral health disorders, costing employers an estimated $5 billion annually.[4] Major depression, social phobia, and alcohol abuse result in the greatest number of lost workdays.[4]

Productivity Decline and Work Impairment/ Cutback

At-work productivity decline due to mental illness (also called work impairment, work cutback, and presenteeism) is also a concern for employers. Due to its usually negative influence on concentration, mental illness is considered a major cause of productivity decline. Both depression and anxiety have been documented to reduce workplace performance; an employee suffering from depression or anxiety loses 2.2 hours of productivity per workday due to their illness.[51] Researchers estimate that 181 million workdays are affected by productivity decline, costing employers $12 billion each year.[4]

FIGURE 2.8 ESTIMATED MEAN NUMBER OF DAYS OF IMPAIRMENT AMONG INDIVIDUALS WITH CHRONIC CONDITIONS DURING A 30-DAY RECALL PERIOD



Source: Kessler RC. Greenberg PE. Mickelson KD. Meneades LM. Wang PS. The effects of chronic medical conditions on work loss and work cutback. *Journal of Occupational and Environmental Medicine*. 2001; 43(3): 218-225.

FIGURE 2.9 MEAN NUMBER OF DAYS OF IMPAIRMENT AMONG INDIVIDUALS WITH A MENTAL ILLNESS OR SUBSTANCE ABUSE DISORDERS DURING A 30-DAY RECALL PERIOD

Condition	Percent with Impairment	Mean Number of Days of Impairment*	Number of STD Claims (per million employees)	Number of LTD Claims (per million employees)
Major Depression	44.5%	4.3	3,374	222
Bipolar Depression			610	70
Panic Disorder	52%	5.1	2,096	93
Generalized Anxiety Disorder	53.5%	5.5		
Psychotic and other Psychiatric Conditions			105	20
Substance Abuse	33.9%	2.3	556	

Source: Kessler RC. Greenberg PE. Mickelson KD. Meneades LM. Wang PS. The effects of chronic medical conditions on work loss and work cutback. *Journal of Occupational and Environmental Medicine*. 2001; 43(3): 218-225.

In total, the 217 million days of work loss and work impairment due to behavioral health disorders cost employers $17 billion annually.[4]

FIGURE 2.10 TOTAL DAYS OF WORK LOSS AND REDUCED PRODUCTIVITY AND ASSOCIATED COSTS

Disorder	Total Days Lost (in millions)	Total Cost (in billions)
Major Depression	136.9	$9.9
Social Phobia	82.9	$7.5
Alcohol Abuse/Dependence	64.3	$6.1
PTSD	61.7	$4.7
Anxiety (GAD)	61.2	$5.4
Panic Disorder	58.3	$4.8
Dysthymia	47.3	$4.1
Agoraphobia	39.3	$3.6
Drug Abuse/Dependence	33.8	$2.5
Bipolar disorder	31.0	$2.5
Total	217.4 million	$16.8 billion

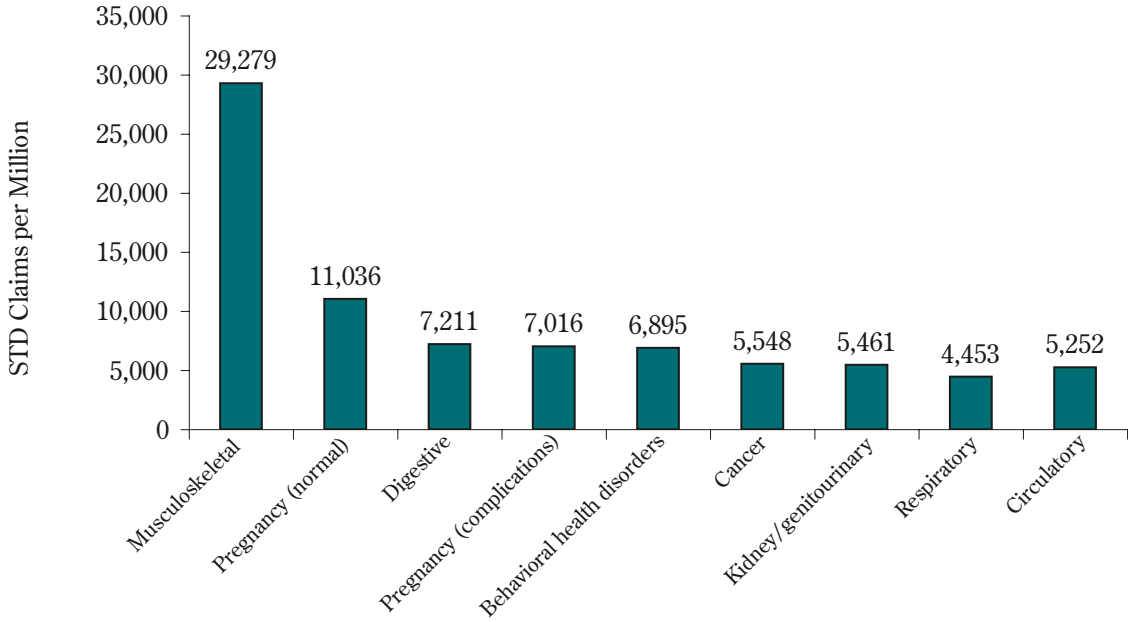
Source: Hertz RP. Baker CL. The impact of mental disorders on work. *Pfizer Outcomes Research*. Publication No P0002981. Pfizer; 2002.

Disability

Worldwide, depression is the leading cause of disability (when measured by the number of years lived with a disability).[12] Mental illness and substance abuse disorders represent the top five causes of disability for people age 15-44 in the United States and Canada (excluding communicable diseases).[52,53] And the World Health Organization estimates that mental illness accounts for 25% of all disability in the United States, Canada, and Western Europe.[53]

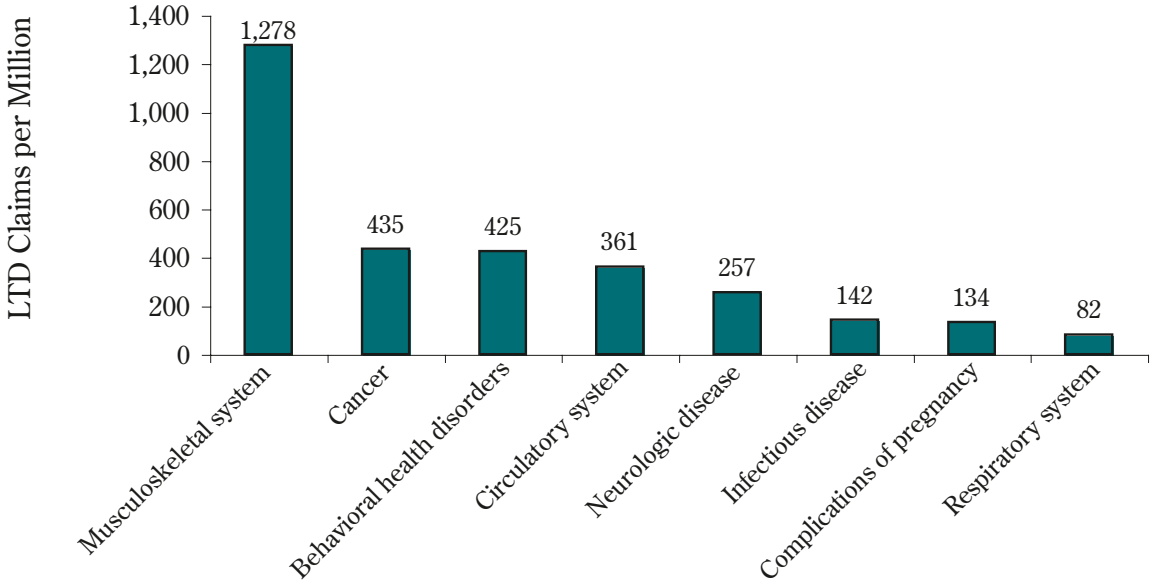
Mental illness and substance abuse disorders (as a group) are a major cause of both short- and long-term disability in the private sector. In fact, these disorders (as a group) are the fifth leading cause of short-term disability and the third leading cause of long-term disability in the United States.[54] Mental illness and substance abuse disorders are not only responsible for a significant proportion of short- and long-term disability claims, they are also responsible for a significant proportion of short and long term disability days. For example, the average STD claim for a behavioral health condition is seven days — the same number of days usually taken for cancer, circulatory system conditions, and complications of pregnancy claims — but more than the average number of days taken for other common causes of short-term disability such as musculoskeletal conditions (six days), normal pregnancy (five days), respiratory conditions (three days) and digestive system conditions (three days).[54]

FIGURE 2.11 SHORT-TERM DISABILITY (STD) CLAIMS PER MILLION BY HEALTH CONDITION



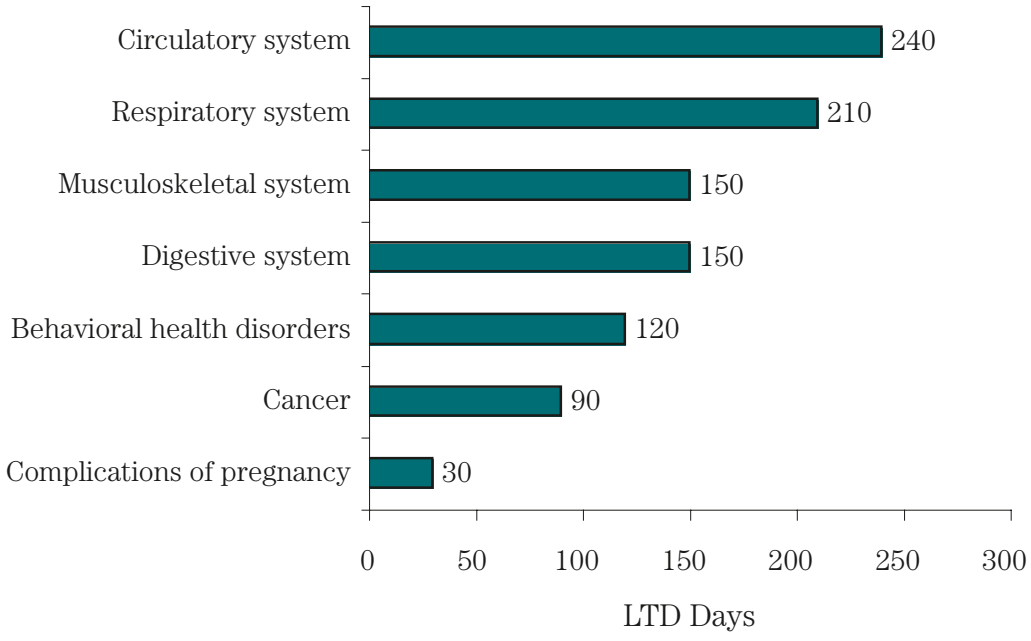
Source: Leopold R. A Year in the Life of a Million American Workers. MetLife Group Disability. New York, New York: Moore Wallace; 2003.

FIGURE 2.12 LONG-TERM DISABILITY (LTD) CLAIMS PER MILLION BY CONDITION



Source: Leopold R. A Year in the Life of a Million American Workers. MetLife Group Disability. New York, New York: Moore Wallace; 2003.

FIGURE 2.13 AVERAGE LONG-TERM DISABILITY (LTD) CLAIM BY CONDITION AND NUMBER OF DAYS



Source: Leopold R. A Year in the Life of a Million American Workers. MetLife Group Disability. New York, New York: Moore Wallace; 2003.

Disability claims and costs can be effectively controlled with active management. Actively managing behavioral health disability claims has been shown to reduce the duration of disability by 23% (17.1 days).[47]

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A note on sources:
References in color are non-federal sources that were not peer-reviewed.

PART II

Center for Prevention and Health Services

National Business Group on Health

The State of Employer-Sponsored Behavioral Health Services in the United States

- Overview of Behavioral Health Services in the United States
- Employee Assistance Services

5. Overview of Behavioral Health Services in the United States

In order to adequately address the behavioral healthcare needs of beneficiaries, medical benefit plans must include benefits for the treatment of mental illness and substance abuse disorders. Large employers realize the importance of behavioral healthcare coverage and almost all large employers offer behavioral healthcare benefits to their beneficiaries. Yet, despite the recognized importance of behavioral health services, the behavioral healthcare delivery system in the United States is rife with problems. The President's New Freedom Commission on Mental Health found that the public behavioral healthcare delivery system is in disarray; its fragmentation leads to unnecessary disability, homelessness, school failure, and incarceration. The private mental healthcare delivery system — the system that delivers employer-sponsored behavioral health services — faces many of the same challenges as the public system such as fragmentation, lack of coordination, and uneven quality.

Despite the fragmentation of the behavioral healthcare system and its associated quality problems, it is innovative; new and effective treatments are continuously developed, tested, and implemented. These treatments and services hold great promise for individuals who suffer from mental illness and substance abuse disorders and for their families.

The following section describes the current scope of employer-sponsored behavioral health services and addresses some of the current problems in the organization, delivery, and financing of the private behavioral healthcare system in the United States.

The Scope of Employer-Sponsored Behavioral Health Services

Three out of five non-elderly Americans have employer-sponsored health benefits. Most large employers offer physical health, behavioral health, and pharmacy benefits to their beneficiaries. In fact, 98% of employees covered by employer-sponsored insurance have mental health benefits and 99.9% have a prescription drug benefit.[1] In addition, many large employers also offer Employee Assistance Programs for their employees.

Behavioral health benefits typically cover "traditional" clinical programs and services such as outpatient services (office-based services), partial hospitalization, inpatient hospitalization, and prescription drug coverage. Only a few plans offer benefits for more specialized intermediate type programs such as targeted case management, 24-hour crisis services, hotlines, assertive-community treatment (ACT) programs, and multi-systemic therapy.[2] Psychotropic medications, another major component of behavioral healthcare, are covered through a separate pharmacy benefit and are therefore usually not considered part of the cost of a specialty behavioral health benefit. Prescription drugs are covered by 99.9% of all health plans.[1]

Benefit Limitation: Unintended Consequences of Benefit Limitation Strategies

Benefits for behavioral healthcare have always been more limited than benefits for physical healthcare services. Yet, despite the limiting of services, during the 1980's and early 1990's employers experienced unprecedented increases in the annual cost of behavioral healthcare benefits. For example, the Washington Business Group on Health (at that time a coalition of 200 Fortune 400 companies) members' behavioral healthcare benefit expenses increased 47% in 1989 and 27% in 1988.[3] The cost increases were fueled by traditional benefit design and a lack of appropriate benefit management.

Employers responded to increasing costs in two ways:

1. They restructured their benefits to further limit inpatient hospitalization, and either expand or add flexibility to include a number of alternative treatments such as partial hospitalization.
2. They hired vendors, such as MBHOs, to manage behavioral healthcare services when delivered in the specialty behavioral healthcare system. Specialty managed behavioral healthcare (MBHOs) companies now manage the majority of behavioral healthcare benefits for employers.

These changes led to an expansion of outpatient and alternative-to-hospital treatment services for patients and thus significantly reduced the use of inpatient care. The reduction in use of inpatient services lead to a significant drop in total spending for behavioral health benefits. In fact, private employers experienced a 50% decline in their behavioral healthcare premiums during the 1990s: the average cost of private employers' behavioral healthcare premiums dropped from 6.1% of total claims costs in 1988 to 3.2% in 1998.[4] [Note: These services and costs figures do not include expenditures for psychotropic drugs, nor behavioral healthcare services delivered in the general medical setting].

Employers have been successful in keeping their specialty behavioral healthcare costs low and relatively consistent over the past eight years. And the total cost of behavioral healthcare has dropped significantly in proportion to general medical spending. Beneficiaries also have access to a larger and growing number of non-hospital specialty behavioral healthcare services and programs. However, while the strategy of intensely managing care and limiting services has lowered costs, it has also created unintended problems. Both patients and providers have complained bitterly about access, quality of care, and unequal benefits that include higher deductibles and co-payments compared to general healthcare services.

Challenges of Limiting Benefits in the Specialty Mental Healthcare System

Access

Behavioral healthcare benefits have always been more limited than physical healthcare benefits. As the Surgeon General's Report on Mental Health notes, the inequality between behavioral and general medical benefit structures has a long and complicated history:

> [restrictive mental health benefits] were motivated by several concerns. Insurers feared that coverage of mental health services would result in high costs associated with long-term and intensive psychotherapy and extended hospital stays. They were also reluctant to pay for long-term, often custodial, hospital stays…These factors encouraged private insurers to limit coverage for mental health services. Some private insurers refused to cover mental illness treatment; others simply limited payment to acute care services. Those who did offer coverage chose to impose various financial restrictions such as lifetime limits on care, as well as separate (and higher) deductibles and co-payments. As a result, individuals paid out-of-pocket for a higher proportion of mental health services than general health services and faced catastrophic financial losses (an/or transfer to the public sector) when the cost of their care exceeded the limits.[5]

Most employers, in order to reduce their behavioral healthcare costs, have limited the use of behavioral health services delivered by behavioral health specialists through instituting out-patient visit limits, day limits on inpatient hospitalization, and higher co-pays for out-patient

care visits. In fact, only 19% of employees with employer-sponsored healthcare do not face limits on behavioral healthcare.[2]

These limitations have traditionally not been applied to general healthcare or to prescription drugs (both psychotropic and general healthcare drugs). So there is usually no difference in the amount a beneficiary must pay in co-pays or co-insurance for psychotropic drugs compared to prescription drugs for other health problems, regardless of the setting where the medication is prescribed. Because co-pays for psychotropic medications are the same as other medications, and because these medications can be prescribed by primary care physicians whose co-pays or co-insurance requirements for visits are much lower than behavioral health specialists, there is an incentive for patients to:

- **Seek care from a clinician in the general medical setting (e.g., a primary care physician).** Because behavioral healthcare benefits are more limited than general medical benefits and require patients to bear a higher burden of cost, many individuals with behavioral health problems seek care from primary care physicians in the general medical setting in order to avoid extra out-of-pocket costs, regardless of the severity or complexity of their condition.
- **Use medications as a sole form of treatment.** Because the combined cost of co-pays for medications and medication management (from a primary care physician) is usually cheaper than the co-pay required for psychotherapy and/or medication management from a behavioral health specialist, patients have an incentive to rely on medication as a sole form of treatment, regardless of the severity or complexity of their condition. Further, because primary care physicians typically do not provide psychosocial interventions (e.g., psychotherapy), patients who chose to use a primary care physician as a provider may not have easy access to non-medication treatment/ modalities.

These unintended incentives are of concern for two reasons. First, as will be expanded upon later in this chapter, the quality of behavioral healthcare delivered in the primary care setting is more uneven than the care delivered in the specialty behavioral healthcare system. Second, numerous studies have shown that for depression and other common mental illnesses, a treatment regiment combining medication and psychosocial interventions such as psychotherapy is more effective than either treatment alone.[5]

FIGURE 3.0 PERCENT OF HEALTH PLANS THAT LIMIT MENTAL HEALTHCARE SERVICE USE

Limitation on outpatient mental health visits, annual maximums	All Plans (avg)
20 visits or less	32%
21-30 visits	31%
31-50 visits	9%
More than 50 visits	9%
Unlimited	19%
Limitation on inpatient mental health days, annual maximums	**All Plans (avg)**
10 days of less	6%
11-20 days	8%
21-30 days	45%
31 or more days	21%
Unlimited	21%

Source: Kaiser Family Foundation. Health Research and Educational Trust. Prescription drug and mental health benefits. *Employer Health Benefits 2004 Annual Survey*. Menlo Park, CA: Kaiser Family Foundation; 2005.

Underutilization of Behavioral Healthcare Services

Despite the increase in the number of individuals with behavioral health disorders who receive treatment, the utilization of behavioral healthcare services — in relation to need — is still low. The discrepancies between utilization and need are of concern because untreated behavioral health problems and disorders are serious and costly. Untreated or poorly treated mental illness is the leading cause of suicide. Further, disability data from private employers clearly show that behavioral health disorders are a leading cause of short- and long-term disability. For more information on disability related to behavioral health disorders, please see *Part I: Major Trends in the Epidemiology, Treatment, and Cost of Behavioral Healthcare in the United States.*

Barriers to Care

While treatment methods for mental illness and substance abuse disorders have advanced over the decades, access to treatment still remains an issue for many Americans. In 2004, the *National Survey on Drug Use and Health* found that 5.1% of all adults in the United States (10.8 million people) reported that they had an unmet need for mental healthcare resulting from insufficient, interrupted, and/or delayed treatment. Of persons with a mental illness, 30.1% (5.9 million) reported an unmet mental healthcare need. Access to treatment is also a concern for children and adolescents. The Center for Mental Health Services (CMHS) estimates that two-thirds of children and adolescents who need mental health services do not receive them.[6] Similarly, treatment for substance abuse and substance dependence is also underutilized. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 23 million Americans needed treatment for substance abuse during 2004, but only 2.33 million received treatment.[7] The reasons for the underutilization of substance abuse services are complex. Many substance abusers are not ready to address their problem and thus do not seek treatment, others face barriers to accessing care.

Reasons for Underutilization of Behavioral Healthcare

Individuals who perceived a need for mental health treatment but did not/were not able get treatment, cited several the following major barriers:

- Thinking the problem could be handled without treatment at the time (46.0%)
- Cost of treatment or insurance problems (45.1%)
- Not knowing where to go for services (22.9%)
- Stigma (22.8)
- Not having the time (18.1%)
- Feeling that treatment would not help the problem (10.3%)
- Fear of being committed or forced to take medicine (7.2%)
- Problems with access other than cost (3.7%)[30]

Individuals age 12 and above who needed treatment for substance abuse and made an effort to get treatment, but did not receive treatment, cited barriers including:

- Cost/insurance barriers (42.5%)
- Not ready to stop using (25.3%)
- Access barriers other than cost (25.3%)
- Stigma (17.8%)
- Did not know where to go for services (9.8%)
- Did not feel the need for treatment/could handle the problem without treatment (8.6%)
- Did not have time (5.4%)
- Thought treatment would not help (1%)[7]

Uneven Quality of Care

Quality of care is a major concern for both beneficiaries and employers. Unfortunately, the quality of behavioral healthcare delivered in the United States is highly uneven, and many Americans receive inadequate care.

The *National Co-morbidity Survey Replication* (NCS-R), described above, found that only 32.7% of patients treated for a mental illness or substance abuse disorders receive adequate treatment.[8] Patients who were treated by a mental health specialist (e.g., psychiatrist, psychologist, social worker, etc) were far more likely to receive adequate treatment than were patients treated in the general medical sector, yet neither group consistently received adequate treatment. In fact, the NCS-R found that only 12.7% of individuals treated in the general medical sector received minimally adequate treatment and only 43.87% of patients treated in the specialty mental health sector received minimally adequate treatment.[8]

Most people with mental disorders in the United States remain either untreated or poorly treated.

— National Co-morbidity Survey Replication (NCS-R)

Minimally adequate treatment was defined based on current evidence-based guidelines and required that patients receive:

Medication Management		Psychotherapy
≥ Two months appropriate medication for the primary disorder plus > four visits to any type of physician for follow-up	***and/or***	≥ Eight psychotherapy visits with any type of health care services professional lasting ≥ 30 minutes

Similarly, a sentinel study from RAND found that patients treated for depression received only 57.7% of the recommended care for their condition. And patients treated for alcohol dependence (one type of substance abuse) received only 10.5% of the recommended care for their condition.[9] In fact, of all patients interviewed in the study, which examined 30 acute and chronic conditions, those with alcohol dependence received the least amount of recommended care (e.g., assessment, treatment referral, etc).[9]

The lack of adequate treatment provided for behavioral health disorders in the general healthcare setting is particularly concerning because so many individuals with mental health and/or substance abuse disorders are seen exclusively by general healthcare providers. Numerous studies have shown that the lack of adequacy in treatment at primary care is the result of several factors. Researchers note that provider factors (e.g., competing demands, inadequate reimbursement, and less training and experience) play a role as well as patient factors (e.g., patients with more severe co-morbid conditions may gravitate to primary care as opposed to specialty mental healthcare providers).[8] Further, some patients may chose to see a primary care clinician or other general healthcare provider in order to avoid the stigma of seeing a behavioral health specialist.

The Promise of Evidence-Based Benefits and Practices

Part of the quality problem in behavioral healthcare is that too few patients receive the recommended evidence-based treatment(s) for their condition(s). "Evidence-based treatment" refers to a treatment program or practice that is based on demonstrated effectiveness.

There are a number of evidence-based and effective treatment modalities for mental illness and substance abuse disorders. These include, but are not limited to:

- Cognitive, interpersonal, and other types of psychotherapies for depression and other common disorders[10]

Effective, state-of-the-art treatments vital for quality care and recovery are now available for most Serious Mental Illnesses and serious emotional disorders. Yet these new effective practices are not being used to benefit countless people with mental illnesses.

Successfully transforming the mental health system, hinges, in part, on better balancing fiscal resources to support providing evidence-based practices.

— President's New Freedom Commission on Mental Health, Final Report

- Collaborative treatment in primary care[10]
- Intensive outpatient care for substance abuse disorders
- Specific psychotropic medications for specific behavioral health disorders and the use of best-practice medication algorithms[10]

Effective Methods of Treatment for Mental Illness Include: [11]

Medications: Medications are effective for many mental illnesses, however, issues of side-effects and safety should be considered.

Psychotherapy: Many psychotherapies, particularly cognitive-behavioral and interpersonal psychotherapies, are supported by research and have efficacy equal to that of medication for some conditions.

Combined treatments: Medication plus psychosocial interventions, such as psychotherapy, usually produces the best results for many conditions.

Psychosocial treatments (in addition to psychotherapy): Psychosocial treatments and services (e.g., assertive community treatment, targeted case management, multisystemic treatment for children with conduct disorder) provide advantages for a number of disorders — particularly to promote rehabilitation and recovery among individuals with the most severe impairments.

Improving Access to Evidence-Based Practices For Children, Adolescents, and Adults With Serious Mental Illnesses

Some evidence-based practices are particularly relevant for individuals with Serious Mental Illness and substance abuse disorders, many of whom do not benefit fully from traditional treatment methods. These individuals include: Adults with Severe and Persistent Mental Illnesses (SPMI), (e.g., schizophrenia, bipolar disorder, etc.), including disorders of late life, (e.g., dementia) and children and adolescents with severe emotional disturbances (e.g., schizophrenia, pervasive developmental disorders, conduct disorder).

Several evidence-based treatment modalities have been identified as being particularly relevant to these groups, including but not limited to:[11]

- Targeted case management
- Assertive community treatment programs (ACT/PACT)
- Therapeutic nurseries
- Therapeutic foster care
- Therapeutic group homes

Targeted Clinical Case Management: The purpose of targeted clinical case management is to coordinate service delivery, ensure continuity, and integrate services.[12] Case management services address the needs of persons with chronic illnesses (including serious and/or chronic mental illnesses), who, due to their symptoms, disability, or other problems are not able to effectively manage their own care. Case managers help patients identify providers and facilities to best meet their needs. Case managers also actively coordinate and monitor the patient's

ongoing treatment ensuring that patients have access to available resources and that those resources are being used in a timely and cost-effective manner. Case management can be implemented as part of a disease management program within the health plan(s) or it may stand alone as a feature to promote the coordination of care for those patients who have not responded to traditional treatment services. It is recommended that, at minimum, case management services include:

- Outreach services
- Assessment services
- Treatment plan development
- Arrangements for service delivery (e.g., referrals)
- Monitoring of services

Assertive Community Treatment Programs: An ACT/PACT program is a comprehensive community-based model for delivering mental health treatment, support, and rehabilitation services. ACT/PACT programs are intended for adults with serious and persistent mental illness who have not benefited from traditional approaches to treatment. The individuals who receive ACT services are those who have the most serious and intractable symptoms of mental illness and experience the greatest impairment in functioning, such as:

- Individuals with diagnoses of schizophrenia, schizoaffective disorder, or bipolar disorder
- Individuals who have difficulty taking care of themselves including meeting basic needs, protecting themselves, maintaining housing and employment
- Frequent users of inpatient psychiatric services
- Individuals who have a co-occurring substance abuse disorder
- Individuals with a previous or current history of trouble with the legal system[13]

Research has demonstrated that ACT/PACT programs lead to better outcomes compared to standard healthcare services for people with Serious Mental Illnesses in the following domains:

- Patient and family satisfaction
- Reduction in psychiatric hospitalization
- Higher level of housing stability
- Improved quality of life[13]

Therapeutic Nurseries for Children [also known as Therapeutic Behavioral Services (TBS)]: Therapeutic nurseries or therapeutic behavioral services (TBS) may be helpful for children with serious behavioral problems, including developmental disabilities and/or serious emotional disturbances. TBS are designed to support children who are at risk for a higher level of care, such as in-patient hospitalization. TBS services can be provided in the patient's home, in the community, or in a childcare setting (but are not a replacement for childcare). Researchers have found that therapeutic nursery programs are an effective method of treatment for seriously troubled children and that these comprehensive programs improve behavior and spur social and emotional growth.[14]

Therapeutic Foster Care: Therapeutic foster care is considered the least restrictive form of out-of-home therapeutic placement for children and adolescents with severe emotional disorders. Care is delivered in private homes with specially trained foster parents who act as

caregivers and therapists.[15] Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed. Research studies have demonstrated that therapeutic foster care can cost half that of residential treatment center placement for certain populations.[16] Further, in one study, previously hospitalized youths who entered therapeutic foster care showed more improvements in behavior and had lower rates of re-institutionalization than did their peers who entered other settings such as out-of-hospital programs, residential treatment centers, or the homes of relatives. Further, the treatment costs of youths in therapeutic foster homes were lower than the treatment costs of youths in the other settings.[17]

Therapeutic Group Homes: For adolescents with serious emotional disturbances, a therapeutic group home provides an environment conducive to social and psychological skill improvement. A therapeutic group home is led by specially trained staff and is located in the community so that adolescent patients can attend school. Each home typically serves five to ten patients and provides an array of therapeutic interventions. Although the types and combinations of treatment vary, individual psychotherapy, group therapy, and behavior modification are usually included.[15] Existing research suggests that therapeutic group home programs produce positive gains in adolescents while they are in the home, but the limited research available reveals that these changes are seldom maintained after discharge.[17]

Unequal Benefits

There has long been concern that the unequal nature of behavioral health benefit structures compared to physical health benefit structures limits access, encourages adverse selection, promotes stigma, reduces quality of care, and leaves under-insured individuals at risk of substantial financial losses due to required out-of-pocket payments. One partial response to these concerns was the Federal Mental Health Parity Act signed into law on September 26, 1996.[18] This act required that, for all employers with more than 50 employees who offered mental health benefits, that the annual or lifetime dollar limits on behavioral health service spending be no lower than any such dollar limits for general medical and surgical benefits offered by a group health plan or health insurance offering coverage in connection with a group health plan. The law provided that employers retain discretion regarding the extent and scope of behavioral health benefits offered to workers and their families (including cost sharing, limits on the number of visits or days of coverage, and requirements relating to medical necessity). The common term for equalizing benefits for all aspects of coverage is known as "parity."[5]

> *A significant approach to increasing the value gained from the expenditure of health care dollars is adoption of evidence-based practices: that is, the purchase of treatments and services that have been scientifically confirmed to improve outcomes.*
>
> — A. Lehman, H. Goldman, L. Dixon, R. Churchill

The Mental Health Parity Act was a step towards equalizing behavioral and general medical benefits. Yet, as noted in the previous section, cost remains a major barrier that keeps individuals (even those with private insurance) from accessing needed care. Over 36 states and the federal government have attempted to reduce financial barriers by further equalizing

behavioral healthcare and general medical benefit structures. The largest employer in the nation, the Unites States government, equalized benefits for their employees in 2001. A number of private companies including Eli Lilly, Northeast Utilities, and CNF Transportation have also begun equalizing their benefit structures.[19]

The move to "equalizing benefits" or implementing parity has been well studied. A number of parity studies have found that equalizing specialty behavioral health and general medical benefit structures will either not increase total healthcare expenses at all, or will increase them by a very modest amount, unusually between 0.2%-0.9% of total healthcare premium.[20] The largest study of parity to date was a four-year study of the Federal Employees Health Benefits Program (FEHB). The study concluded that when parity mental health and substance abuse were implemented and managed, total healthcare costs for most of the plans did not increase beyond the increases over the same period that were observed in a matched group of health plans that did not have a parity benefit. Furthermore, for most of the plans that implement parity, out-of-pocket spending declined for individuals who used behavioral health services, reflecting improved insurance protection without increasing use or total spending.

Equalizing Benefits: A Case Study of the Federal Employees Health Benefits Plan

The Federal Employees Health Benefits Program (FEHB) is the largest employer-sponsored health insurance program in the nation, serving more than eight million beneficiaries, including retirees. It offers approximately 250 health plan choices, with healthcare costs of $29 billion annually.[19]

In 1999, by executive order, the Office of Personnel Management (OPM) was directed to provide full parity for the treatment of all mental illness and substance abuse disorders listed in the DSM-IV (when services were delivered by network providers in FEHB plans). This directive required the managed care plans participating in FEHB to equalize the behavioral health benefits and general medical service benefits they offered (i.e. leveling co-pays and co-insurance, reducing day limits on mental health hospitalization, etc) starting in 2001. Prior to this directive, FEHB plans offered behavioral health benefits similar to private companies. They limited outpatient visits, restricted inpatient days, and required higher co-pays.

Like private employers, the federal government was concerned that the cost increase associated with expanding behavioral health benefits would be prohibitive and that the quality of care might be negatively affected if care was managed. Thus, OPM required an evaluation of the impact of parity in the FEHB Program.

The FEHB study is the largest evaluation of the addition of a behavioral health parity benefit ever conducted and one of the few studies in behavioral healthcare utilization that compared parity plans with similar non-parity plans over a defined period of time. The fact that this study was conducted with the largest employer in the United States, gives even greater significance to its findings.

The results of this study are as follows:[19]

- **Equalizing benefit structures did not increase overall healthcare costs as compared to similar health plans with a non-parity benefit.** Total cost increases among FEHB plans that offered equalized behavioral health and general medical services were similar to employer-sponsored health plans that did not equalize their benefit structures. Cost increases were not attributable to parity.
- **The implementation of equalized benefits did not increase administrative costs significantly, if at all.** Two-thirds of the equalized benefit FEHB plans reported incurring no added administrative costs upon implementing parity between physical health and behavioral healthcare benefits. Further, no plan expressed concerns about any cost increases that they did incur.
- **Access to, and utilization of, mental health and substance abuse services increased for both adults and children, but the increases were comparable to trends seen among plans without equal benefit structures.** Thus, the increases were not attributable to parity, but rather to general trends in behavioral healthcare utilization.
- **Beneficiaries' out-of-pocket costs declined.** Financial barriers to accessing specialty behavioral healthcare services were reduced.

6. Employee Assistance Services

Limitations of Traditional Behavioral Health Benefits

Traditional employer-sponsored behavioral health benefits offered through a health plan address only those problems that meet criteria for medical necessity (i.e. symptoms that meet criteria for a mental illness or substance abuse disorder). However, many employees who do not have a diagnosable mental illness or substance abuse disorder nonetheless experience significant stressors related to work and/or family-life. These stressors can have a major impact on employee productivity and job satisfaction.

Employee assistance services can address this gap by providing consultation to employees with emotional, psychological, work-related, or other problems; treating those who could benefit from short-term counseling and referring those who need longer-term services to appropriate providers within the health plan. Employee Assistance Programs (EAPs) can also provide education, prevention, and training services to employees and employers that will build resiliency skills and help both parties deal with common problems as they arise.

Research has shown that workplace behavioral risk management methods that build on EAP core technologies can help employers improve productivity and reduce the direct and indirect costs of behavioral health conditions.[21]

> *…the human body is the most complex machine on earth and the only one that doesn't come with a service manual. …employers devote substantial financial resources to required or recommended preventive maintenance on a wide variety of corporate assets, yet choose to wait until employees become broken and then spend vast company funds on repairs.*[22]
>
> — R. William Whitmer, et. al.

Employee Assistance Programs

An Employee Assistance Program (EAP) is an employer-sponsored service designed to assist employees, their spouses and their dependent children, in finding help for emotional, drug/alcohol, family, and other personal or job related problems.

Employee assistance is a proven strategy for assisting employees (and their families) with personal and work related problems, difficulties, and concerns that may affect their work performance. Employee Assistance Program (EAP) services provide assessment, evaluation, referral, and follow-up services for a full range of problems. In the event that the employee is on short-term disability, EAP may also provide return-to-work services, such as preparing the supervisor and employee for reentry into the workplace. EAPs also provide supervisory consultation and educational services on an ongoing basis.

Core Technologies of Employee Assistance Services

EAP activities and processes are defined by its core technologies. According to the Employee Assistance Programs Association the core technologies represent the essential components of the employee assistance profession.[23] They consist of the following:

- Consultation with, training of, and assistance for organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance

the work environment, and improve employee job performance, and outreach to and education of employees and their family members about the availability of EAP services.
- Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance.
- Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance.
- Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services.
- Consultation to work organizations in establishing and maintaining effective relations with treatment and other service providers and in managing provider contracts.
- Consultation to work organizations to encourage availability of and employee access to health benefits covering medical and behavioral problems, including, but not limited to alcoholism, drug abuse, and mental and emotional problems.
- Identification of the effects of employee assistance services on the work organization and individual job performance.

The core technologies provide the basic framework for employee assistance activities. The core technologies do not provide for on-going therapy or counseling, but rather focus on employee productivity through prevention, intervention, and management training.

The History of Employee Assistance

Industrial Alcohol Programs and Employee Assistance Programs (EAP) came into existence in the early 1940's with a focus on employee alcohol use and productivity.[24] Over time, EAP's scope was expanded to a broader array of issues that affected productivity, attendance, and/or presenteeism.

> *The best managers increase the health of the workers whom they manage.*[22]
>
> — Abraham Maslow

During the 1980's, growth of EAP was fueled by the national emphasis on drug-free workplaces. Drug-free workplace initiatives included pre-employment drug screening and, in some instances, random testing of employees. During this time, the Department of Transportation developed regulations that required random drug screening for employees driving company vehicles. These regulations included provisions for EAP to provide intervention services for employees who tested positive for drugs.

In the 1980's and 1990's employers turned to managed care as a remedy for controlling the unsustainable annual increases in total healthcare costs. Behavioral healthcare cost increases were exceeding those of general health. In response, employers changed behavioral health benefits by placing limits on the number of services each beneficiary could receive annually. As an additional measure to control costs, many employers established annual and/or lifetime dollar limits on behavioral health benefits. Utilization management further controlled access to care.

With the introduction of managed care, EAP experienced a fundamental change in scope and function. Many private EAP companies opened, providing corporations with comprehensive services ranging from management and supervisor consultation and training to increased counseling services. In addition, many managed behavioral health organizations (MBHO) developed EAP programs that offered benefit managers a one-stop shop for purchasing behavioral health services. Employers "expanded" their behavioral healthcare benefits by providing "free" EAP counseling sessions to employees and dependents. This

arrangement allowed beneficiaries to access help for problems, such as marriage and family concerns, that did not meet medical necessity criteria for treatment, but could result in diminished job performance.

The Provision of Employee Assistance Services

Employee Assistance Programs (EAPs) are generally provided by employers or jointly by employers and unions. EAP services are delivered in three ways:

1. *Internal programs* provide on-site services staffed by company employees;
2. *External programs* or contracted programs provide services in several locations, generally convenient to employees, and are staffed by employees of the contracted vendors; and
3. *Supplemented internal programs* combine contract providers and internal EAP Staff to provide services on-site and off-site.

Employees access EAP services through two avenues. First, managers can refer employees to EAP services. In many companies, managers are trained to refer employees with declining or deteriorating job performance to EAP for assessment. Second, employees may self-refer to EAP services. Approximately 80% of EAP clients are self-referred, while 20% are management referrals.[25]

Employee Assistance Providers

EAP providers represent a variety of professional identities including psychologists, social workers, professional counselors, substance abuse counselors, nurses, and pastoral counselors. However, the employee assistance profession has identified the skills and knowledge needed to administer and deliver EAP services as unique from those of the other helping professions. In 1986, the Employee Assistance Professional Association developed a credentialing process that established minimum requirements for EAP practitioners.[26] The Certified Employee Assistance Professional (CEAP) defines minimum requirement for providing EAP services. Like other professional certification and licensures, an examination and continuing education is required. Many states have passed separate licensure laws for the practice of EAP.

According to the Society for Human Resource Management's 2005 Benefits Survey Report, EAPs are offered by approximately 75% of employers. The table below shows a slight increase in the number of employers offering these programs. It also shows a corresponding decrease in the number of employers providing behavioral health benefits.

FIGURE 3.1: PERCENT OF EMPLOYERS OFFERING EAP AND BEHAVIORAL HEALTH BENEFITS

Percent of Employers Offering EAP and Behavioral Health Benefits					
	2001	2002	2003	2004	2005
Employee Assistance Programs	68%	68%	67%	70%	73%
Behavioral Health Benefits	77%	73%	71%	72%	72%

Source: Society for Human Resource Management. 2005 Benefits Survey Report. Available at: www.shrm.org/hrresources/survey. Accessed 10-25-05.

While the employee assistance profession has developed credentialing and accrediting procedures, standardization is not uniform and there is room for improvement. Some programs have expanded services to include work/life programs, preventive services, concierge services, and counseling services. Some human resources departments define employee assistance as a benefit, while others define it as a management tool. Gaps exist relative to integration with labor/employee relations, disability management, health promotion, and health plans.

Overlapping Services and Gaps in Care

The services offered by traditional Employee Assistance Programs have become duplicative with the services offered by employer's health plans, disability management programs, and health promotion programs. This has created inefficiencies and accountability problems. Simultaneously, other important behavioral health services such as prevention programs, early intervention services, and workplace organizational assessments have been overlooked

Health plan costs are increasing and the current employee population is aging and developing chronic health conditions. Employers are faced with the dilemma of controlling both health plan costs and disability costs while maximizing employee productivity. Employers will need to develop new strategies to more effectively integrate the services and programs they offer in order to reduce waste and maximize the value of behavioral health services.

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A note on sources:
References in color are non-federal sources that were not peer-reviewed.

PART III

Center for Prevention and Health Services

National Business Group on Health

Recommendations to Improve the Design, Delivery, and Purchase of Employer-Sponsored Behavioral Healthcare Services

- Recommendations Directed at Health Plan Benefits and Services
- Recommendations Directed at Disability Management Vendors and Services
- Recommendations to Improve Employee Assistance Program Services

Recommendations to Improve the Design, Delivery, and Purchase of Employer-Sponsored Behavioral Healthcare Services

The recommendations featured in this chapter are meant to guide employers as they develop their medical and behavioral health benefit plans. Employers are encouraged to add these recommendations to contract language with Managed Care Organizations (MCOs), Managed Behavioral Health Organizations (MBHOs), Pharmacy Benefit Managers (PBMs), and/or Disability carriers as appropriate. Adoption of the recommendations will require employers to change their vendor contract language and to make changes to their benefit structures. Adoption of recommendations regarding best-practice implementation and quality improvement measures will necessitate that employers instruct their MCO, MBHOs, PMBs to track patient and provider data. Wherever possible, the management vendors should incorporate the recommended standards as a part of their normal provider performance review. Employers should require these vendors to present the findings of these reviews annually.

The National Committee on Employer-Sponsored Behavioral Health Services (NCESBHS) also recommends that quality improvement organizations such as the National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Council (URAC), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) review their existing quality standards related to behavioral healthcare and add the NCESBHS recommendations, specific to quality improvement and tracking, if they are not already present. Specific changes to NCQA's MCO and MBHO Guidelines are suggested in *Appendix B: Measuring Quality in Behavioral Healthcare.*

How to Use the Recommendations of the National Committee on Employer-Sponsored Behavioral Healthcare Services (NCESBHS)

Decision-makers should evaluate the recommendations of the NCESBHS in context of their company's needs.

- Benefit managers should use these recommendations to evaluate their current benefit design.
- Benefit managers should use these recommendations to evaluate the practices of their current and future healthcare managers (i.e. MCOs, MBHOs, PBMs).
- Benefit managers should use these recommendations to evaluate their current and future disability management protocols and operations.
- Decision-makers should use these recommendations to define the scope of services offered by their Employee Assistance Program (EAP).
- Decision-makers should use these recommendations to develop programs of prevention and early intervention.
- Decision-makers should use these recommendations to develop the policies and procedures for integrating health plans, EAP, disability management, and prevention programs.
- Decision-makers should use these recommendations to develop plans for evaluation.

I. Recommendations Directed at Health Plan Benefits and Services

1. Recommendations to Improve the Delivery of Covered Behavioral Healthcare Services in the General Medical Setting

a. Documentation and Monitoring

PROBLEM: Too often, patients seen in the general healthcare setting are treated for a behavioral health condition without proper documentation of the diagnosis for which they are being treated. Specifically, there is often no documentation of a diagnosis, there is a lack of association between a documented diagnosis and a prescribed treatment or medication, or the diagnosis is inaccurate. This has been documented as a common problem in primary care practice and among other non-psychiatrist physicians. The lack of correlation between the treatment offered and an accurate diagnosis often leads to improper treatment, costly care, and poor outcomes.

RECOMMENDATION: Any physician or appropriately licensed clinician who administers treatment for a mental health or substance abuse disorder, including the prescription of a psychotropic drug, must document the diagnosis for which the treatment/medication is being given in the patient's medical record. To this end, health plans should require providers to:

- Register in the medical record the diagnosis(es) for which psychotropic medication(s) are being prescribed;
- Provide information supporting the diagnosis, including time course and patterns of symptom development, including current symptoms of severity;

- Document attempts to obtain historical information from collateral sources when appropriate; and
- Document obtaining receipt of information and coordination of care with previous providers when feasible and appropriate.

b. Addressing the High-Risk of Co-Morbidity

PROBLEM: Individuals with certain chronic, general medical conditions are at high risk for developing, or already have, co-morbid depression. Co-morbid depression and other common mental health and substance abuse conditions can affect the severity of the primary medical condition and/or reduce an individual's ability to comply with his/her treatment regimen.

RECOMMENDATION: Anyone with a chronic or persistent (i.e. duration of 4-12 weeks or longer) medical illness or symptom(s), that results in a functional impairment that lasts for two weeks or longer, should be screened for depression. It is best-practice to screen chronically medically ill patients for all common behavioral health conditions. But, due to the lack of resources in some clinical practices, it is recommended that clinicians — at minimum — screen for depression. It is important to remember that to make a diagnosis of depression, other mental health and substance abuse disorders must also be considered. There are several evidence-based screening instruments currently available; the National Committee on Employer-Sponsored Behavioral Health Services recommends the 13-item Emotional Health Inventory (EHI-13) or the nine-item Patient Health Questionnaire (PHQ-9).

Patients with the following conditions or symptoms have been found to be at relatively high risk for depression:

- Alzheimer's disease
- Cancer
- Chronic back pain
- Chronic headaches
- Chronic insomnia
- Chronic obstructive pulmonary disease (COPD)
- Chronic pelvic pain
- Coronary heart disease
- Diabetes
- End stage renal disease
- Fibromyalgia
- Hip fracture
- Irritable bowel syndrome
- Multiple sclerosis
- Organ transplants
- Parkinson's disease
- Pregnancy (pre- and post-partum)
- Stroke

c. The Importance of Tracking Patient Progress

PROBLEM: Too often, when a patient is identified as having a mental health and/or substance abuse disorder and begins treatment, his/her progress is not appropriately monitored longitudinally. Similarly, patients' treatment plans are often not reviewed or updated.

RECOMMENDATION: If a physician or other appropriately licensed provider makes a diagnosis of a mental health condition or substance abuse disorder and initiates treatment for this condition (including prescribing psychotropic drugs), s/he should be held responsible for monitoring, on a regular basis, the patient's clinical condition. The

diagnosis, treatment plan, and updates should be documented in the patient's medical record. We recommend that clinicians consider monitoring patient progress using a standardized and evidence-based instrument. There are several such instruments currently available; the National Committee on Employer-Sponsored Behavioral Health Services recommends the 13-item Emotional Health Inventory (EHI-13) or the nine-item Patient Health Questionnaire (PHQ-9). If no progress has been made in the initial phase of treatment (e.g., 4-12 weeks), the provider should consider changing the treatment strategy or refer the patient to a behavioral health specialist. All treatment actions should be documented in the medical record.

- The monitoring instrument should be billable in the same fashion as a lab test by the provider. In turn, health plans should consider reimbursing the physician (or other appropriately licensed provider) who is the primary clinician for the treatment of the behavioral health condition to administer and interpret the instrument.

d. Collaborative Care

PROBLEM: Numerous research studies have shown that patients with mental illness and substance abuse disorders, specifically depression, anxiety,[1] and alcohol dependence disorders, do not consistently receive the evidence-based care that is indicated when delivered in the primary care setting. There is strong evidence supporting the use of "collaborative care" for depression and anxiety disorders in primary care practice settings. The key elements of collaborative care include:

- Patient screening and assessment for a behavioral health condition and development of an initial treatment plan
- Patient education and behavioral activation
- Treatment (pharmacotherapy and/or psychotherapy)
- Follow-up/monitoring by care/disease manager
- Treatment adjustment (for patients whose symptoms are not improving)
- Referral to a behavioral health specialist when appropriate
- Consultation between a behavioral health specialist and the primary care team, particularly patients whose symptoms are not improving

It is important to emphasize that employer-sponsored health plans typically cover most of these key elements if they are delivered face-to-face by a licensed clinician. The main exceptions are the coordination and monitoring of treatment by a case/disease manager, particularly via telephone; and consultation between a behavioral health specialist and the primary care treatment team, unless it involves face-to-face contact with the patient. (In addition, few plans reimburse for supervision of case managers by primary care providers.) More than ten large clinical trials, in a wide range of practice settings, have demonstrated the feasibility of improving depression treatment and outcomes via collaborative care, relative to usual care.

RECOMMENDATIONS: Collaborative care should be widely implemented, when patients are treated for mental health or substance abuse disorders in part or in whole in the primary care setting. To that effect:

- Employers should include collaborative care services as a part of the standard benefit package, and require their management vendors (i.e. MCOs, MBHOs, and PBMs) to operationalize the delivery and payment of the collaborative care program.
- Individuals with high cost medical diseases (e.g., diabetes) should be enrolled in a disease management program that formally includes a behavioral healthcare component.

- Employers should set specifications for disease management programs in their disease management vendor RFPs and contracts. Specifications should include providing tailored behavioral healthcare services within disease management programs to individuals with co-morbid physical and mental health conditions.
- Employers should pay for case/disease management services for major depression and anxiety disorders. Payment for case management and specialty consultation can be implemented in various ways, depending on the practice setting.
- Two major mechanisms for payment are recommended: use of a clinical Current Procedural Terminology (CPT) code that would allow reimbursement for non face-to-face clinical activities (including telephonic consultation with the patient and/or other physicians) and/or administrative payments (such as a case rate) for the management of care by entities such as MCOs, MBHOs, EAP vendors, or disease management companies, etc.

Note: A CPT code, used for billing purposes, is any one of a set of codes intended to describe services and procedures provided by a physician or other healthcare provider.

2. Recommendations to Improve Collaboration Between Providers in the General Healthcare System and the Specialty Behavioral Healthcare System

a. Referrals to the Specialty Behavioral Healthcare System

PROBLEM: There is a lack of coordination and follow-up between primary care physicians and specialty behavioral healthcare providers after a referral is made.

RECOMMENDATION: If the primary care physician refers a patient to specialty care for the treatment of a behavioral health condition s/he is responsible for documenting, assisting, and monitoring the referral. A referral includes giving the patient the name of a specialist or an MBHO's 1-800 number referral line.

At minimum:

- The primary care physician should document in the medical record that the patient was referred, the reason for the referral, and, if applicable, notify the MBHO that a referral was made.
- If the primary care physician continues to be involved in the general medical treatment of the patient, s/he should continue to monitor the persons' behavioral health condition when they are seen for a general health condition.

Best Practice:

- The primary care physician, with the patient's permission, should contact the specialty care clinician and communicate the need for referral and any other relevant clinical data.
- Assuming that the primary care physician's office has the resources needed, they should check with the specialist's office to see if the patient was seen. Or, if the patient was referred to his/her MBHO referral service, the primary care physician should contact the MBHO to facilitate follow-up care.

RECOMMENDATION: When a patient is referred to a behavioral health specialist for care, and the primary care physician continues to be involved in the treatment process, the specialist should contact the referring primary care physician and communicate (orally and/or in written form) the patient's status and the responsibilities of both parties for

treatment and follow-up care. All communication should be consistent with HIPAA requirements and any other state privacy or confidentiality guidelines.

b. Improving the Collaboration Between Disease Management Programs, General Medical Care, and Specialty Behavioral Healthcare

PROBLEM: Too often, patients with chronic illnesses (who are particularly at risk for depression and other common behavioral health disorders) are enrolled in disease management programs, but are not assessed for co-morbid behavioral health disorders. Further, disease management programs are rarely coordinated with enrollees' other medical and/or behavioral healthcare providers.

RECOMMENDATION: Employers should require their disease management vendors, as part of their regular practice, to periodically screen all patients enrolled in their respective programs for depression and other common behavioral health disorders, and coordinate care with other providers as indicated.

3. Recommendations to Improve Benefit Design for Behavioral Health Screening and Treatment Services

a. Equalizing Benefits Structures

PROBLEM: Most employer-sponsored health plans have higher co-pays and more limitations on behavioral healthcare services than for general healthcare services, with the exception of psychotropic drugs and behavioral healthcare treatments provided by non-psychiatrist physicians in the general medical setting (e.g., primary care physicians). There is ample evidence that these limitations present financial barriers to accessing needed specialty behavioral health treatment services, especially less intensive services and evidence-based services. Research indicates that many of the problems identified by the National Committee on Employer-Sponsored Behavioral Health Services, such as the high number of patients with mental illness and substance abuse disorders who do not receive optimal care, could be in part related to the financial barriers associated with using specialty behavioral healthcare services.[2] Further, recent evidence has shown that the employer costs associated with equalizing the amount patients must pay (i.e. out-of-pocket costs) for behavioral healthcare and general healthcare are minimal.[3]

RECOMMENDATION: Employers should examine their medical/surgical and behavioral health benefit structures and should assess the feasibility of eliminating or reducing the financial barriers to using specialty behavioral healthcare services. Where possible, employers should make patients' out-of-pocket costs for behavioral healthcare services comparable to general healthcare services (i.e. a patient's co-pay to see a primary care physician should be the same as the co-pay to see an appropriately licensed behavioral healthcare specialist).

The National Committee on Employer-Sponsored Behavioral Health Services supports employer's movement to voluntary parity (i.e. equalizing benefits) given the evidence of clinical benefit and the evidence that introducing parity does not increase overall healthcare costs if the behavioral healthcare services offered are appropriately managed. Plans may also include incentives that reduce out-of-pocket costs to beneficiaries that are fully compliant with recommended treatment guidelines and case management/disease management services.

b. Reimbursement for Non-Psychiatrist Physicians

PROBLEM: Non-psychiatrist physicians (and other appropriately licensed non-behavioral health clinicians) are sometimes not (or perceive they will not be) reimbursed for screening, assessing, and diagnosing mental health and substance abuse disorders as a primary or secondary condition. These realities and perceptions discourage some general healthcare physicians from addressing behavioral health conditions in their patient population. Other practitioners address behavioral health conditions in their practice, but do not code the activity appropriately for fear of lack of reimbursement.

RECOMMENDATION: Non-psychiatrist physicians (and other appropriately licensed non-mental clinicians) should be reimbursed for screening, assessing, and diagnosing mental health and substance abuse disorders as a primary or secondary condition. Physicians and other appropriately licensed providers should be paid for issuing primary or secondary mental health and substance abuse diagnoses by their contracted entity (e.g., MCO for PCPs). Capitated arrangements with providers need to clearly include the screening, diagnosing, and referring of patients with behavioral health disorders in the scope of practice. Health plans should distribute clear information to relevant providers.

- Given the current multiplicity of approaches as to whether non-behavioral healthcare specialists (e.g., primary care physicians) are reimbursed for treatment services for behavioral health disorders (as opposed to the initial screening and diagnosis) health plans should be clear as to their policy regarding payment to primary care physicians, medical specialty providers, and other non-behavioral health providers for follow-up treatment sessions billed under behavioral health CPT codes. These policies should be well publicized to primary care physicians and other non-mental health providers and their clinical/business administrators.

4. Recommendations to Improve the Accuracy and Quality of Prescribing Psychotropic Medications in the General Medical and Specialty Behavioral Healthcare System

a. Adoption of a national best-practice guideline for the prescribing and monitoring of psychiatric drug interventions

PROBLEM: There is a lack of standardization and the use of best-practices in the prescribing of psychotropic drugs and the monitoring of patients prescribed these drugs.

RECOMMENDATION: There are a number of national practice guidelines that recommend best-practices for the use of these medications; but no single guideline has been accepted universally as of yet. Employers would like for all of their MCO, MBHO, and PBM's to adopt a nationally accepted standard best-practice guideline for the prescription and monitoring of psychiatric drug interventions. The National Business Group on Health encourages its MCO and MCHO members to adopt a single best-practice standard.

b. Annual assessment of provider performance in relation to the nationally accepted standard best-practice guideline chosen

RECOMMENDATION: Employers should require their healthcare managers (i.e. MCOs, MBHOs, and PBMs) to annually assess their provider's performance in relation to the nationally accepted best-practice guideline they have chosen. Employers should also require their healthcare managers (i.e. MCOs, MBHOs, and PBMs) to provide them with a

summary of the data collected, problems that were identified, and the performance plan improvement to address these problems, annually. This will require formal tracking to determine both compliance and non-compliance issues.
The annual plan should address the following:

- **Psychotropic drug prescription patterns of providers and the psychotropic drug use patterns of patients within the plan(s).** All drug classes should be categorized by physician (or licensed practitioner) prescription pattern including: antidepressants, antipsychotics, anti-anxiety agents, stimulants, anti-manic agents, and other drug classes that are used predominately for the treatment of behavioral disorders. Prescribers should be identified as to whether they are within the norm of national best-practice standards for both dosage level and diagnostic appropriateness. An emphasis should be placed on identifying and evaluating providers that under-prescribe or over-utilize in relationship to guidelines for each diagnostic category. As the majority of some psychotropic drug classes are prescribed by non-psychiatrists, both primary care providers and psychiatrists need to be assessed. Both providers and patients who are not within the ranges of national best-practice standards should be identified and a plan for practice improvement should be presented annually. Recommended interventions should involve all healthcare management vendors (i.e. MCOs, MBHOs, and PBMs). *It is critical that the management entities responsible for the management of non-drug interventions, both medical and psychiatric, be involved in the oversight of the psychotropic drug improvement interventions and that those managers have behavioral health expertise sufficient to assist in the implementation and management of this plan.*
- **Patient usage data by drug class should also be collected.** Dosage levels, duration of medication use, diagnostic fit, and adherence to the prescribed medication regimen should be reviewed using nationally accepted best-practice standards.
- **Physician adherence to specified plan recommendations regarding the use of medications for specific diagnoses.** For example, if a national best-practice standard cautioned against use of antidepressants without a mood stabilizer for patients with bipolar spectrum disorders, this would be a focus of review.

In addition, the scientific literature has identified a number of quality problems in the prescription of psychotropic drugs. Employers should encourage their MCOs, MBHOs, and PBMs to address some of these issues in their annual survey and practice improvement plan:

- Increasing use of stimulant medication among children and adolescents for the treatment of Attention Deficit and Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD).
- Issues surrounding the prescription and use of anti-depressants among pediatric populations.
- The frequent prescription of psychotropic drugs without adequate explanation to the patient of why the medication is being prescribed, how to use it, what the medication is likely to do, how long it will take to work, and common side-effects.
- The prescription of multiple medications of the same class without an adequate rationale (e.g., crossing over medications when tapering one and starting another for a documented reason; use when history indicates failed adequate single medication-in-class trials, etc).

- Inadequate assessment by the provider of reasons for patient non-compliance with medication including adequacy of patient education, clinician-patient relationship, financial barriers, side-effect profiles, and coordination with other psychosocial treatments.

c. Periodic Review of Formulary

RECOMMENDATION: The formulary should be reviewed and adjustments to the formulary should made based on information garnered from the review findings (described in 4b) with emphasis on medications that, when appropriately used, result in the best patient outcomes and controlled total healthcare costs. Favorable formulary positions should be based on a medication's ability to reduce total healthcare costs and disability — not only the price of the medication.

5. Recommendations to Improve Behavioral Healthcare Services for Individuals with Serious Mental Illness

a. Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)

PROBLEM: Historically, the scope of employer-sponsored benefits has been limited to traditional treatment services such as office-based professional services, partial hospitalization, and acute inpatient care. This benefit structure has been appropriate for many persons with mild to moderate impairment from their behavioral health disorders. However, employers provide healthcare coverage for a number of children and adults with Serious Mental Illness and substance abuse disorders that have not responded to traditional treatment services. Fortunately, there are a number of evidence-based treatment programs designed for these populations. These programs have been in place for decades and have been paid for primarily by Medicaid and state mental health agencies. Numerous outcome studies have demonstrated the effectiveness of these evidence-based treatment programs. Typically, these programs are intermediate level programs that deliver more intensive care than traditional outpatient services, but are less restrictive and less costly than inpatient care and have been shown to have better patient outcomes. In order for beneficiaries to gain access to these preferred evidence-based treatment modalities, employers need to 1) include these treatment modalities in their benefit plan, and 2) add to their network the appropriate providers and programs to deliver these services.

RECOMMENDATION: There are several evidence-based treatment modalities for individuals with Serious Mental Illnesses and/or substance abuse disorders. At minimum, employers should provide coverage for the full-range of evidence-based treatment modalities listed below, including; targeted clinical case management, assertive community treatment programs, therapeutic nurseries, and therapeutic group homes.

The inclusion of evidence-based treatment services in standard benefit plans requires alternate or flexible benefit structures. We suggest two approaches:

- Decide on a case-by-case exception basis, using a pre-determined severity of illness criterion to determine which patients would benefit from these treatment services.
- Employers can add these services to their standard benefit plan and allow all those who meet medical necessity criteria to use the benefit.

The recommended evidence-based treatment modalities include:

- Targeted Clinical Case Management: Case management can be implemented as part of a disease management program within the health plan(s) or it may stand alone as a feature to promote the coordination of care for those patients who have not responded to traditional treatment services. It is recommended that, at minimum, case management services include:
  - Outreach services
  - Assessment services
  - Treatment plan development
  - Arrangements for service delivery (e.g., referrals)
  - Monitoring of services
- Assertive Community Treatment (ACT) Programs: At minimum, ACT/PACT programs should include:
  - Services that are targeted to a specific group of individuals with Serious Mental Illness
  - A comprehensive and flexible range of treatment services tailored to the patient's needs, that would include case management, medication management, psychosocial rehabilitation, and crisis intervention services all provided by the same treatment team
  - Interventions provided in vivo rather than in hospital or clinic settings
  - Services that are available on a 24–hour basis
  - A small staff to patient ratio
- Therapeutic Nursery Services or Therapeutic Behavioral Services (TBS): TBS is an intensive treatment program provided by a team of multi-disciplinary team of providers and lead by a physician. Therapeutic nursery service programs should provide a range of services including assessment, behavioral intervention, medications (if appropriate) and case management, based on a treatment plan. Therapeutic nursery services are generally for children aged 5-8 years who have serious behavior problems.
- Therapeutic Group Homes: At minimum, therapeutic group home interventions should include the following components: a group home led by specially trained staff that provides an array of therapeutic interventions including individual psychotherapy, group therapy, and behavior modification therapy. Therapeutic group homes are generally for adolescents who cannot be effectively treated at home, but do not require inpatient hospitalization.

b. Providers of Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)

RECOMMENDATION: Employers should direct their MCOs or MBHOs to add providers that can deliver the above referenced evidence-based practices to their networks. Many of these providers primarily serve the public behavioral healthcare system (e.g., Medicaid) and may be better equipped to provide acute and long-term care for seriously and chronically ill children and adults.

Employers should supplement their existing inpatient provider network with facilities that have a range of 24-hour acute care and/or crisis programs tailored to seriously mentally ill children and adults. Some of these programs are operated by community mental health centers that may not be a part of employers' current networks.

The National Business Group on Health has worked with the National Council for Community Behavioral Healthcare (the group that represents many of these providers) to assist in the enrollment of these providers in private sector networks.

c. Annual Review of Behavioral Health Treatment Modalities

PROBLEM: Under 5a we have listed some, but not all, of the evidence-based practices that have been identified for the treatment of mental illness and substance abuse disorders. There are a number of other identified evidence-based treatments not listed and still other interventions that are emerging as best-practices.

RECOMMENDATION: Employers should ask their MCOs and or MBHOs to annually review behavioral health treatment modalities and make recommendations to them about whether these new treatment modalities should be added to their benefit structure.

II. Recommendations Directed at Disability Management Vendors and Services

6. Recommendations to Improve Employer Management of Behavioral Health Problems that Qualify for Short- and/or Long-Term Disability Benefits

a. PROBLEM: A wide variety of procedures exist for addressing behavioral health disability claims. Some employers have standardized protocols, but other employers do not require the evaluation of a beneficiary for as long as two months after the disability claim was received. Similarly, several large disability management vendors, when interviewed by members of the NCESBHS, stated that absent specific employer directives they routinely approve two months of disability benefits for depression. Further, many individuals with mental illnesses are recommended for disability benefits by general healthcare physicians without ever being evaluated by a behavioral healthcare specialist.

RECOMMENDATION: Employers should review their short and long-term disability management programs and develop a more proactive and integrated approach for managing disability related to behavioral health disorders. The goals of the approach are to: (1) minimize the medical and economic impact through early intervention, (2) ensure proper evaluation, diagnosis, and treatment, and (3) to coordinate medical personnel, disability managers, other managed care entities, and employee assistance staff.

- Given the severity of any psychiatric condition that warrants disability benefits, we recommend that employers require their disability management vendors or other appropriate management vendors to refer patients recommended for disability benefits by a general healthcare physician to a behavioral healthcare specialist for evaluation and/or treatment within two weeks of their application for disability. Concurrently, all individuals on the disability rolls for a behavioral health condition should be referred to a behavioral health specialist. All communication should be consistent with HIPAA requirements and any other relevant privacy or confidentiality guidelines.
- Employers should also require their disability management vendors or other appropriate management vendors to ensure that a treatment plan has been established

for any patient on disability for a behavioral health condition. It is imperative that someone with behavioral health expertise review this treatment plan.

- Employees disabled because of a behavioral health disorder should be referred to EAP, if present. EAP professionals, working with the employee and the employee's supervisor, can address the psychosocial issues associated with the employee's return to work. All communication should be consistent with HIPAA requirements and any other relevant privacy or confidentiality guidelines.

III. Recommendations to Improve Employee Assistance Program Services

7. Recommendations to Improve the Structure of Employee Assistance Programs (EAPs)

a. PROBLEM: Over time, some of the services offered by EAPs have overlapped the services provided by MCOs and/or MBHOs. This redundancy may be cost-ineffective for employers and confusing to beneficiaries trying to access care for a behavioral health problem. In addition, employers have a need for many services that full-service EAPs are well suited to provide.

RECOMMENDATION: EAPs should not duplicate services offered through the health plan (MCOs and MBHOs), but rather be re-structured, if necessary, to provide the following functions:

- Support management in addressing issues of productivity and absenteeism that may be caused by psychosocial problems
  - Support effective supervisory practices
  - Assist employees with deteriorating performance relating to behavioral or other health problems
  - Address work-related issues influencing disability or return to work
  - Assist in the identification of stress-related problems that may be a result of work organization
  - Assist the organization in its response to drug-free workplace policies and regulations and disaster and terrorism preparedness as is relates to psychosocial issues
  - Serve as an internal consultant to management regarding issues of employee behavioral health
- Assist in the design and development of a structured program to deliver health promotion and healthcare education tools that significantly affect employee and beneficiary health and productivity and lead the effort to deliver behavioral healthcare education programs
- Functionally coordinate with other health services including health plan, disability, and health promotion

b. RECOMMENDATION: Based on an analysis of current EAP services, the NCESBHS found that an important function that Employee Assistance Programs (EAP) provide is assessment and short-term counseling for individuals at risk of a behavioral health disorder and those with problems of daily living (e.g., divorce counseling, grief processes). In the restructuring of EAP, as recommended in 7a, it is essential that these services be retained and provided by an EAP or other entity.

c. RECOMMENDATION: Employers should conduct an organizational assessment to evaluate the effects of work organization on employee health and job satisfaction. Employee assistance staff should work closely with Human Resources and Organization Development personnel to structure appropriate interventions when necessary.

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APPENDIX A:

Overview of the President's New Freedom Commission on Mental Health

Achieving the Promise: Transforming Mental Health Care in America, Final Report of the President's New Freedom Commission on Mental Health July 2003

In April 2002, The President's New Freedom Commission on Mental Health was established. The Commission was charged to conduct an in-depth study and review of the prevalence of mental illness, treatment services, and treatment funding. The Commission's Interim and Final Reports concluded that the behavioral healthcare delivery system's fragmentation leads to unnecessary and costly disability, homelessness, school failure, and incarceration. The report further profiled delivery system failures including:

- Fragmentation and gaps in care for children;
- Fragmentation and gaps in care for adults with serious mental health problems;
- High unemployment and disability for people with Serious Mental Illness;
- Lack of care for older adults with mental illnesses; and
- Lack of national priority for mental health and suicide prevention.

The Commission's final report, *Achieving the Promise: Transforming Mental Health Care in America*, outlines the characteristics of a new and responsive behavioral healthcare delivery system with six primary goals.

Goal 1: Americans Understand that Mental Health is Essential to Overall Health

Research demonstrates that mental health is key to overall physical health. The World Health Organization has identified mental illness as the leading cause of disability worldwide. Good mental health improves the quality of life for people with serious physical illnesses and may contribute to longer life in general.

Unfortunately, several obstacles to achieving this goal remain. For example, stigma frequently surrounds mental illness, prompting many people to hide their symptoms and avoid treatment. Stigma is particularly pronounced among older adults, ethnic and racial minorities, and residents of rural areas. Suicide also presents serious challenges. Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves. Many Americans are unaware of suicide's toll and its global impact. It is the leading cause of violent deaths worldwide, outnumbering homicide and war-related deaths.

To address these problems the Commission recommends implementing a national campaign to reduce the stigma associated with seeking care and a national strategy for suicide prevention. This will entail:

- Targeted public education initiatives to increase understanding of mental illness and to encourage help-seeking behaviors.
- Targeted public education to increase awareness about the effectiveness of mental health services and encourage people to seek treatment, thus reducing the stigma and discrimination associated with mental illness.
- Media-oriented and other types of mental health awareness campaigns to inform the public about where and how to obtain help.

- Swiftly implementing and enhancing the National Strategy for Suicide Prevention to serve as a blueprint for communities and all levels of government.

The Commission also urged social service agencies, research institutions and the government to address mental health issues with the same urgency as physical health. In order to accomplish this the Commission recommends reviewing existing scientific literature and initiating new studies. The Commission also notes that flexible, accountable financing regulations that will pay for effective treatments and services is an essential aspect of transforming mental healthcare in America.

Goal 2: Mental Healthcare is Consumer and Family Driven

The New Freedom Commission found that our current mental health system is in shambles. The mental healthcare system is comprised of all of the agencies and services used by those with mental illnesses for the purpose of identification, diagnosis, treatment, management, rehabilitation, and support. These include: housing services, rehabilitation services, education, child welfare, substance abuse services, general healthcare, criminal justice, and juvenile justice. Financial assistance and health benefit programs for the mentally ill include Social Security Supplemental Income (SSI), Social Security Disability Income (SSDI), and Medicaid and/or Medicare. When functioning properly, these different agencies and programs would be coordinated and would deliver the best possible services to all those in need. However, these services are fragmented and disjointed. Consumers are overwhelmed and confused when they attempt to access and integrate mental healthcare, support services, and disability benefits across the multiple, disconnected programs that span federal, state, local and private agencies. Too often, services and programs for the mentally ill are driven by financing rules and regulations rather than best-practice strategies.

Individuals with mental illnesses face many challenges in the current system:

Unemployment

- As a group, individuals with mental illness suffer from one of the highest rates of unemployment in the nation, despite the fact that most individuals with mental illness want to work and feel they could work with the adequate support. Due to the high rate of unemployment many individuals with mental illness live in poverty. This is especially problematic because the stress and dangers associated with poverty (homelessness, substance abuse, victimization, etc) can further exacerbate mental illness by impeding treatment.
- Due to restrictions and regulations, SSI/SSDI recipients with mental illness who rely on Medicaid for healthcare and medications find that returning to work actually lowers their income level as they are no longer eligible to receive their much needed medical benefits from Medicaid. Those individuals who lose their Medicaid coverage and cannot afford their medications or other treatments out-of-pocket are forced to stop treatment or quit working and re-enter the SSI/SSDI rolls.

Lack of affordable housing

- People with Serious Mental Illnesses are at a higher risk for homelessness. The mentally ill represent a disproportionate number of the homeless, especially the chronically homeless. This problem stems in part from a lack of adequate housing. Affordable and safe housing is difficult for people with mental illness to access due to discrimination, lack of support, a

history of substance abuse or a criminal record, and/or an inability to provide rental history information.

Criminal justice system and custodial care

- People with Serious Mental Illnesses are overrepresented in jails throughout the United States. Incarcerated individuals with mental illnesses often do not receive the treatment they need due to inadequate mental healthcare services in jails.
- Youth with Serious Mental Illnesses are also overrepresented in the juvenile justice system.
- When parents cannot pay for the long-term treatment of a seriously mentally ill child, they are sometimes forced to give up custody and turn their child over to the state in order for the child to receive the treatment s/he needs. Such action is traumatizing for both parent and child, places a financial burden on state agencies, and can put the child at risk for neglect, abuse, and adjustment problems.

To address these problems the New Freedom Commission recommends the creation of a Comprehensive State Mental Health Plan that would create a new partnership among federal, state, and local governments. This plan would organize and oversee mental health services, be given flexibility in the use of federal funds, and would be held accountable for improving services and outcomes. In addition, the Commission recommends that the Department of Health and Human Services (DHHS) develop a cross-department mental health agenda with the goal of better aligning federal policy on mental health treatment and support services.

The Commission also recommends that a consumer and family driven model should be established for all mental health services. In a consumer-driven system consumers choose the programs and providers that they feel will help them the most. According to the Commission, "consumers must stand at the center of the system of care and consumers' needs must drive the care and services that are provided." Specifically, each adult and child with a mental illness should have an individualized plan of care that describes the services and support they need to reach recovery. Providers should develop these care plans with the full participation of consumers and families and take into consideration the needs and preferences of consumers. Consumers and families should also be involved in the planning and evaluation of mental health services. Finally, the Commission recommends the protection and enhancement of consumer and family rights including an end to unnecessary institutionalization and discrimination in employment and housing, a reduction in the use of seclusion and restraints, and remedying the forces that cause parents to trade custody for care.

Goal 3: Disparities in Mental Health Services Are Eliminated

Minority populations are underserved in the mental healthcare system. Unfortunately, minorities are less likely to have access to available mental health services, are less likely to receive needed mental health services, often receive poorer quality care, and are significantly under-represented in mental health research.

In addition to the barriers faced by the general population in seeking, accessing, and maintaining care, minorities face additional barriers including mistrust, racism, and discrimination. Minorities also have different help-seeking behaviors and beliefs about illness, health, and treatment.

Individuals who live in rural areas also lack access to quality mental healthcare services. This causes them to enter care later in the course of disease than their urban counterparts and thus enter care with more serious and disabling symptoms. The advanced state of disease in the rural mentally ill requires more expensive and intensive treatments, increasing overall costs.

To address these problems the Commission recommends that states address and monitor racial and ethnic disparities in access, availability, quality, and outcomes of mental health services. This would include setting standards for culturally competent care, collecting data to identify points of disparity, evaluating services for effectiveness and consumer satisfaction, and establishing benchmarks and performance measures. The Commission also recommends recruiting and retaining racial and ethnic minorities in mental health professions, including mental health research, and establishing workforce- training programs to target multicultural populations. To address the needs of rural communities the Commission recommends that the Department of Health and Humans Services (DHHS) convene a cross-agency workgroup to examine rural workforce issues.

Goal 4: Early Mental Health Screening, Assessment, and Referral Services Are Common Practice

For consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience mental health problems. Emerging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability. Without intervention, child and adolescent disorders frequently continue into adulthood.

In a transformed mental healthcare system, the early detection of mental health problems in children and adults - through routine and comprehensive testing and screening - will be an expected and typical occurrence. At the first sign of difficulties, preventive interventions will be started to keep problems from escalating.

The Commission specifically recommends promoting the mental health of young children through:

- Early detection and treatment of mental disorders. This can result in a substantially shorter and less disabling course of illness.
- A coordinated, national approach to these issues that will help eliminate social and emotional barriers to learning and will promote success in school and in other community settings.
- Information, supports, and treatment for parents of children with mental illness.

To adequately meet the mental health needs of children, school health programs must be expanded and improved. Collaboration between families and professionals is needed to develop, evaluate, and disseminate effective approaches for providing mental health services and supports to youth in schools along a continuum of care. To this end the Commission recommends that:

- Federal, state, and local child-serving agencies fully recognize and address the mental health needs of youth in the education system.
- School mental health programs improve educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores.
- The Commission concedes that mental illnesses and substance abuse disorders often occur simultaneously. Integrated treatment strategies offer the best hope for individuals with co-occurring illnesses.
- Implementing systematic screening procedures will identify mental health and substance use problems and treatment needs in all settings in which children, youth, adults, or older adults are at high risk for mental illnesses, or in settings in which a high occurrence of co-occurring mental and substance use disorders exists.
- Integrated treatment can improve client engagement, reduce substance abuse, improve mental health status, and reduce relapses for all age groups.
- Primary healthcare plays an important role in screening for mental disorders across the lifespan and can connect patients to treatment and support systems. The Commission recommends that collaborative care models be widely implemented in primary healthcare settings and reimbursed by public and private insurers.

The Commission also notes that the federal government should better coordinate the funding and the clinical care provided by publicly funded community health clinics to consumers with multiple conditions, including physical, mental, and co-occurring substance use disorders.

Goal 5: Excellent Mental Healthcare is Delivered and Research is Accelerated

While research has yielded important advances in knowledge of mental illness etiology, prevention and treatment, "the delay is too long before research reaches practice." Further, even when innovations become widely available at the community level, too often the clinical practice is highly uneven and inconsistent with the original treatment model that was developed. Evidence-based practices (EBPs) are available, but they do not reach all who could benefit from them. Emerging best practices — those practices that are promising but less thoroughly researched — are also available, but they too are underutilized by providers. EBPs are limited in practice settings due to unfavorable reimbursement policies, lack of workforce training, and the shortage of qualified mental health professionals.

Research on specific mental health topic areas is lacking and should be promoted, including research on minority disparities in mental healthcare, the effect of long-term medication use, the impact of trauma, and the acute care of mental illnesses. Research on the treatment of mental illness and on the recovery process in mental illness should be supported, funded, and "sped-up."

To further advance prevention and treatment, the Commission recommends that mental health researchers and professionals work to bridge the gap between science and service. The Commission recommends that the DHHS provide leadership to implement and evaluate evidence-based practices through demonstration projects nationwide with the goal of

advancing knowledge, disseminating findings, facilitating workforce development, and ensuring financial support. The Commission also recommends changing reimbursement policies to support providers in the use of EBPs.

Goal 6: Technology is Used to Access Mental Healthcare Information

New technology that aids in administering medications can reduce medical errors and prevent death or unnecessary injuries. Unfortunately, the technology and communications infrastructure in public and private mental healthcare lags far behind other healthcare sectors.

In a transformed mental health system, advanced communication and information technology will empower consumers and families and will be a tool for providers to deliver the best care. Consumers and families will be able to regularly communicate with the agencies and personnel that deliver treatment and support services and that are accountable for achieving the goals outlined in the individual plan of care. Information about illnesses, effective treatments, and the services in their community will be readily available to consumers and families. Improving access to mental healthcare is especially needed in underserved, rural, and remote areas. To be ultimately useful, systems must be carefully designed to produce care that is safe, effective, patient-centered, timely, efficient, and equitable.

The Commission recommends that DHHS lead a review of how to best deliver and finance e-health and telemedicine services in consultation with private payers, insurers, state agencies, and other federal programs. Health technology and telehealth should be used to improve access to and coordination of mental healthcare, especially for Americans in remote areas or in underserved populations. The Commission notes that:

- Encouraging the use of computers and video cameras, sending e-mail reminders, transmitting results by telephone, and assisting provider follow-up in underserved, rural, and remote communities could significantly improve care for individuals of all ages who have multiple chronic health conditions, including severe illness or disability.
- Ensuring that reimbursement policies become flexible enough to allow evidence-based practices to be implemented will improve access.
- Coordinating both traditional clinical care and e-health visits will improve quality of care.
- Services delivered through new technology should be sustained to promote continuity in care.

To further advance the role of technology in providing quality mental healthcare services, the Commission recommends developing and implementing integrated electronic health records and personal health information systems. Studies show that electronic health records improve the quality, accountability, and cost-effectiveness of healthcare services. Providers urgently need universal electronic access to the latest evidence-based practice guidelines, best practice models, ongoing clinical trials, scientific research, and other health information.

To address the inadequacies of the current system, the Commission recommends that DHHS and Veteran's Affairs (VA) lead a voluntary public-private initiative to design and adopt a secure, privacy-protected, electronic health record and a system of health information exchange for providers to share information with the approval of consumers.

Summary of the President's New Freedom Commission on Mental Health
Solutions for the Future

The President's New Freedom Commission on Mental Health found that the current mental health system is in disarray.

- Mental health services are fragmented
- Gaps in mental health service exist for both adult and child/adolescent populations
- Serious mental illness too frequently results in unemployment and disability
- Older adults have a substantial unmet need for mental health services
- Mental health is not given the priority in research, funding, and attention that is deserves

The report identified three main barriers that prohibit Americans from getting the mental healthcare services that they need:

1. The stigma that surrounds mental illness
2. The unfair limitations and financial barriers placed on mental health benefits in private health insurance that limit service use
3. The fragmented mental healthcare service delivery system

Mental health benefits need revision in order to adequately serve the needs of Americans. When designed effectively, improved and expanded mental health service coverage does not lead to higher costs. Appropriate and high-quality services can be incorporated into a health plan without raising the overall cost for the employer. The U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Mental Health Services (CMHS) recommend the following benefit design features to improve mental health service delivery without increasing total costs:

- Cover a wide range of clinically effective services and treatments including inpatient, outpatient, intensive outpatient, residential setting and partial day programs, and medication. In addition, allow patients to trade days of inpatient hospitalization for intermediate treatment services when deemed clinically appropriate. Substituting short periods of care at high costs (inpatient care) for longer periods of less costly care (outpatient or residential care) will improve treatment outcomes by extending the period of care while not increasing overall cost.
- Reduce enrollee cost-sharing requirements to promote access to care. Progressively tiered patient co-insurance programs can increase access by determining the patient's out-of-pocket costs based on how many visits they have per period. For example, the first three visits could be covered, the subsequent 10 visits could require a co-pay of $20 and the 10 visits after that could require a co-pay of $30. This encourages patients to seek first time services by reducing their out-of-pocket costs, but discourages excessive use by raising the price for visits after the critical time period.
- Use the same design for mental health and substance abuse, benefit to reduce confusion, stop patients and physicians from making inappropriate diagnoses to maximize coverage, and allow for simultaneous treatment of co-existing conditions.
- Cover intermediate services only from network providers to ensure access to appropriate services, but discourage service misuse or abuse.
- Encourage the use of network providers in PPO and POS plans by providing patients with financial incentives and ensuring that network providers are easily accessible and provide high-quality care.
- Provide catastrophic coverage for enrollees. While most enrollees will have minimum costs associated with mental illness, some, especially those with chronic conditions, will have catastrophic costs and will need coverage to continue treatment.

Reference:

Adapted from:
New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Publication No. SMA-03-3832. Rockville, MD; 2003.

APPENDIX B:

Measuring Quality in Behavioral Healthcare

Measuring Quality in Behavioral Healthcare

Metrics for quality in behavioral healthcare are limited for children, adolescents, and adults. Behavioral healthcare metrics are relatively new to National Committee on Quality Assurance (NCQA's) HEDIS measures.[1] In 2004, the original HEDIS mental health measures (adopted in 2001) were expanded to include quality measures relating to chemical dependency and substance abuse disorder treatment. Currently, the HEDIS measures include:[2]

- Mental Health Utilization – Inpatient Discharges and Average Length of Stay
- Mental Health Utilization – Percentage of Members Receiving Services
- Follow-up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Chemical Dependency Utilization – Inpatient Discharges and Average Length of Stay
- Chemical Dependency Utilization – Percentage of Members Receiving Services

While these additions improved the comprehensiveness of the HEDIS measures, there are still improvements to be made and the current HEDIS measures are not extensive enough to adequately document and track progress in treatment or service delivery.

The National Committee on Employer-Sponsored Behavioral Health Services (NCESBHS) recommends that quality improvement organizations such as the National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Council (URAC), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) review their existing quality standards related to behavioral healthcare and add the NCESBHS recommendations, specific to quality improvement and tracking, if they are not already present.

As an example, the NCESBHS reviewed the 2006 NCQA MBHO and MCO Guidelines and suggested clarifications and additions. These changes are highlighted below.

Please note that guidelines detailed below are summaries of the current NCQA MBHO and MCO guidelines. For a complete listing of the 2006 NCQA MBHO guidelines please refer to www.ncqa.org. Items highlighted in yellow are proposed additions to current guidelines drafted by the National Committee on Employer Sponsored Behavioral Health Services and do not necessarily reflect the views of the NCQA.

NCQA MCO and MBHO Guidelines (2006)[2]

MBHO QI3: Health Services Contracting

The organization's contracts with individual practitioners and providers, including those making Utilization Management (UM) decisions, specify that contractors cooperate with the organization's Quality Improvement (QI) program.

INTENT

The organization's contracts with practitioners and providers foster open communication and cooperation with QI activities.

ELEMENT A — Practitioner Contracts

Contracts with practitioners specifically require that:

- Practitioners cooperate with QI activities
- The organization has access to practitioner treatment records, to the extent permitted by state and federal law
- Practitioners maintain the confidentiality of enrollee information and records.
- Practitioners provide evidence of coordination of care between mental health professionals, primary care providers, and/or other medical care physicians in the treatment record.

MBHO QI6: Enrollee Satisfaction

The organization implements mechanisms to assess and improve enrollee satisfaction.

INTENT

The organization monitors enrollee satisfaction with its services and identifies potential areas for improvement.

ELEMENT B — Scope of Survey

The organization's satisfaction survey addresses at least the following factors:

- Services
- Accessibility
- Availability
- Acceptability
- Coordination of care*

Explanation and Exceptions:

The organization may measure satisfaction across the full range of its operations or include the specified factors. The organization must have evidence of systematic methods to assess enrollee satisfaction annually for each of the following components:

- Organizational services
- Accessibility, availability and acceptability of behavioral healthcare practitioners programs and services
- Consumer's satisfaction with the type and quality of coordinated care services

Evidence includes data collection, aggregation of results and analysis of findings. Regardless of who is responsible for data collection and initial analysis, the results must be reported through the QI program.

The organization's satisfaction survey will include measures that reflect opportunities for coordination between mental health services, general medical care (in the primary care or specialty medical care setting), and social services.

MCO QI9: Continuity and Coordination of Behavioral Healthcare

The organization monitors the continuity and coordination of care that enrollees receive and takes actions, as necessary, to ensure and improve continuity and coordination of care.

INTENT

The organization uses information at its disposal to coordinate transitions in behavioral healthcare across the delivery system and assures continuity of care upon termination of behavioral healthcare practitioner contracts.

ELEMENT A — Identify Opportunities for Improvement

At least annually, the organization identifies and acts on opportunities to improve coordination of behavioral healthcare by:

- Collecting data
- Conducting quantitative and causal analysis of data to identify improvement opportunities
- Identifying and selecting an opportunity for improving the exchange of information across the continuum of behavioral health services
- Identifying and selecting an opportunity for improving access and follow-up to appropriate behavioral health practitioners in the network
- Taking action on the opportunity for exchange of information across the continuum of behavioral health services
- Taking action on the opportunity for improving access and follow-up to appropriate behavioral health practitioners in the network
- Using evidence-based tools to screen for mental health conditions during routine medical interviews*

MBHO QI10: Continuity and Coordination Between Behavioral Health and Medical Care

The organization collaborates with relevant medical delivery systems or primary care physicians to monitor and improve coordination between behavioral health and medical care. [Note: If the organization does not have any formal relationship with the medical delivery system through contracts, delegation, or otherwise, NCQA considers this standard non-applicable.]

INTENT

The organization collaborates with relevant medical delivery systems or PCPs and uses information at its disposal to coordinate behavioral health and medical care.

ELEMENT A — Data Collection

At least annually, the organization has collected data about the following opportunities for collaboration between medical and behavioral healthcare:

- Exchange of information
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
- Appropriate uses of psychopharmacological medications
- Management of treatment access and follow-up for enrollees with coexisting medical and behavioral disorders
- Primary or secondary preventive behavioral health program implementation.
- Use of evidence-based tools for screening

Explanation:

Clinical literature indicates that behavioral and medical disorders can interact to affect an individual's health. The MBHO may perform medical/behavioral collaboration activities across MCO clients.

Screening Opportunities

An emphasis is to be placed on screening for the most common and treatable mental health conditions seen in primary care: depression, anxiety, and substance abuse disorders.

MBHO and MCO QI13: Standards for Treatment Record Documentation

The organization requires treatment records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

INTENT

The organization establishes treatment record standards to facilitate communication, coordination and continuity of care and to promote efficient, confidential and effective treatment.

ELEMENT A — Treatment Record Criteria

The organization has policies and distributes the policies to practice sites that address:

- Confidentiality of treatment records
- Treatment record documentation standards
  - including a requirement that collaborative care activities between mental health and primary care/specialty medical care must be documented in the medical record
- An organized treatment record keeping system and standards for the availability of treatment records
- Performance goals to assess the quality of treatment record keeping with an emphasis on providing evidence that there has been collaboration between the primary care and mental healthcare system

MCO UM10: Evaluation of New Technology

The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits package. This includes behavioral health procedures, pharmaceuticals and devices.

INTENT

The organization has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in the benefits package to keep pace with changes and to ensure that enrollees have equitable access to safe and effective care.

ELEMENT B — Description of the Evaluation Process

The organization's written evaluation process includes:

- The process and decision variables that the organization uses to make determinations
- A review of information from appropriate government regulatory bodies
- A review of information from published scientific evidence
- A process for seeking input from relevant specialists and professionals who have expertise in the technology including, when relevant, behavioral health specialists and professionals

MBHO and MCO UM11: Assessing Satisfaction With the Utilization Management (UM) Process

The organization evaluates enrollee and practitioner satisfaction with the UM process.

INTENT

The organization continually assesses its customer's satisfaction with the UM process to identify areas of improvement.

ELEMENT A — Assessing Satisfaction

The organization annually assesses satisfaction with the UM process by:

- Collecting and analyzing data on enrollee satisfaction for improvement opportunities including collaboration of care between behavioral health and primary care/specialty medical care
- Collecting and analyzing data on practitioner satisfaction for improvement opportunities including collaboration of care between behavioral health and primary care/ specialty medical care
- Taking action designed to improve enrollees' satisfaction based on its assessment of enrollee data
- Taking action designed to improve practitioner satisfaction based on its assessment of practitioner data

MCO UM13: Procedures for Pharmaceutical Management

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

INTENT

The organization develops and regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence.

ELEMENT A — Policies and Procedures

The organization's policies and procedures for pharmaceutical management include:

- The criteria used to adopt pharmaceutical management procedures
- A process that uses clinical evidence from appropriate external organizations
- An expectation that MCOs and/or PBMs make psycho-pharmacy data available to MBHOs

Explanation:

Regarding data sharing

- MCOs and MBHOs and PBMs should share claims data for the treatment of behavioral health conditions whether delivered within primary care or the specialty mental healthcare system.

References:

1. Mellman TA, Miller AL, Weissman EM, Crismon ML, Essock SM, Marder SR. Evidence-based pharmacologic treatment for people with severe mental illness: A focus on guidelines and algorithms. *Psychiatric Services*. 2001; 52; 619-625.
2. National Committee on Quality Assurance. Standards and guidelines. 2006 Standards for the Accreditation of Managed Behavioral Health Organizations. Washington, DC: National Committee on Quality Assurance; 2005. Available online (restricted access): www.ncqa.org.

APPENDIX C:

Acknowledgements

The National Business Group on Health (Business Group) established the National Committee on Employer-Sponsored Behavioral Health Services (NCESBHS) in January of 2005 through a contract from the Center for Mental Health Services, a division of the Substance Abuse and Mental Health Services Administration, and the U.S. Department of Health and Human Services. The committee was charged with reviewing the current state of employer-sponsored behavioral healthcare services. The committee was asked to identify current problems in the screening, diagnosis, treatment, and management of mental illness and substance abuse disorders in the United States and to propose solutions to address those problems.

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About the Center for Prevention and Health Services (CPHS)

The Center houses the Business Group's projects and resources that relate to the delivery of preventive and other health services through employer-sponsored health plans and worksite programs. Through the Center, employers can find practical toolkits to address preventive health and health promotion issues at the worksite. Employers will find current information and recommendations from federal agencies and professional associations, model programs from other employers, and the latest clinical and health services research results. In addition, the Center provides opportunities for employer participation in teleconferences and in-person solutions workshops. Currently, the Center has initiatives in racial and ethnic disparities in health and health care, terrorism and public health emergency preparedness, maternal and child health, preventive services, health services research and quality, health and work performance, benefit design, and wellness programs.

For more information, visit http://www.businessgrouphealth.org/prevention/index.cfm or contact Kathryn Phillips at phillips@businessgrouphealth.org.

About the National Business Group on Health

The National Business Group on Health, formerly the Washington Business Group on Health, is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. The Business Group represents over 200 members, primarily Fortune 500 companies and large public sector employers, who provide health coverage for approximately 50 million U.S. workers, retirees, and their families. The Business Group fosters the development of a quality health care delivery system and treatments based on scientific evidence of effectiveness. The Business Group works with other organizations to promote patient safety and expand the use of technology assessment to ensure access to superior new technology and the elimination of ineffective technology.

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