The Benefit to Cost Impact of EAPs

By

Jim Wrich-1995

BENEFIT TO COST ANALYSIS (BCR)

Many organizations have estimated the benefit to cost ratio of their EAP. An important factor in developing such ratios is the cost and effectiveness of mental health and chemical dependency treatment. If such treatment is overpriced or ineffective, the BCR will be adversely affected. Besides treatment costs, the formula also includes the cost of the EAP's operation plus cost of time off to get treatment versus the cost of sick leave pre/post program use.

The following table summarizes studies conducted for organizations over the past 15 years by J. Wrich & Associates, Inc. and include some of the largest and most prominent public and private employers, including both unionized and non-union work environments.

EMPLOYER		PAYBACK PERIOD	BENEFIT TO COST RATIO			OVERALL RATING	
Code	Employees	Months	1st Year	5th Year	10th Year	Score*	Rank
A	900,000	10	1.3 to 1.0	7.2 to 1.0	13.7 to 1.0	12.5	1
B	60,000	14	.8 to 1.0	7.0 to 1.0	15.0 to 1.0	14.5	2.5
C	49,000	18	.4 to 1.0	8.5 to 1.0	15.0 to 1.0	14.5	2.5
D	14,000	23	(2.1) to 1.0	6.8 to 1.0	15.8 to 1.0	17.0	4
E	45,000	11	1.1 to 1.0	6.4 to 1.0	12.3 to 1.0	19.5	5

F	30,000	30	(2.1) to 1.0	5.6 to 1.0	15.3 to 1.0	24.0 6
G	4,500	28	(2.4) to 1.0	6.4 to 1.0	15.2 to 1.0	24.5 7
H	4,800	33	(2.1) to 1.0	4.9 to 1.0	13.6 to 1.0	32.0 9
I	2,500	27	(2.7) to 1.0	5.4 to 1.0	13.8 to 1.0	32.0 9
J	26,000	41	(5.3) to 1.0	5.2 to 1.0	16.7 to 1.0	32.0 9
K	4,200	38	(2.5) to 1.0	3.3 to 1.0	9.0 to 1.0	41.0 11

* Scores are an accumulation of rankings in four categories: Payback Period; 1st year BCR; 5th year BCR; and 10th year BCR. Example: Employer B ranked 4th in Payback Period, 4th in 1st year BCR, 1st in 5th year BCR and tied for 5th in 10th year BCR for a cumulative score of 14.5. Such results would not have been possible had the type, level and duration of mental health and chemical dependency treatment not been appropriate. Yet, except for a brief period in the 1980s, mainstream medical practice and insurance plans have not effectively dealt with these issues.

During the 1980s, as the practical advantages of mental health and substance abuse treatment began to be recognized, the demand grew. Since these disorders had not previously been covered by insurance, naturally the claims experience began to grow as well. As a percentage of the meager amounts that had previously been expended on mental health and chemical dependency, the trend line increases appeared to be dramatic. But in absolute dollars, these increases and the percentage they represented of total health care expenditures were modest. By the end of the 1980s, insurance plans that covered mental health and substance use disorders were expending approximately 8 percent to 10 percent in this area and studies indicated that these expenditures had a favorable impact on overall health care costs. Unfortunately, the positive cost impact of mental health and substance abuse treatment was buried in the large increases in medical costs generated by HMO adverse-selection processes and other factors such

as more sophisticated treatment methods, expensive equipment, an aging population and malpractice litigation.

At the same time, It should also be noted that mental health and substance use treatment providers were not totally blameless. While small in number, some were drastically overcharging and keeping some patients far longer than was medically necessary. This was particularly true of inpatient hospital based adolescent psychiatric and chemical dependency programs. Non-hospital based primary residential programs, such as Hazelden and Betty Ford, were less than half the cost and frequently provided superior care. Moreover, they shared their expertise with health care organizations desiring to start up their own programs. Ironically, they often had difficulty securing insurance reimbursement because the health care industry, dominated by medical doctors, hospitals and insurance companies, regarded treatment that could be delivered largely by non-medical professionals in non-hospital settings as a threat to their economic interests. Lower cost outpatient care was also excluded from coverage except in states such as Minnesota where a legislative mandate was passed over the objections of the insurance carriers and hospitals. Since the insurance companies had little economic incentive to reduce costs, the most cost effective care was frequently not covered. All of this set the stage for the development of what has become known as the managed behavioral health care industry.

Managed Behavioral Health Care Organizations made two compelling arguments to employers when marketing their services. First, that there was gouging by providers, and a cursory audit of the employers claims could nearly always produce a few high outlier claims which the MBHO firm could declare to have been unnecessary, often without studying the facts of the case. Second, they avowed that mental health care was essential and millions in need were getting no care at all, but it had to be managed to assure that the early trend line did not continue its course or parallel what was happening on the medical side of the employees' benefits program.

During the sales process mental health and chemical dependency treatment providers were generally cast in an unfavorable light. They were often portrayed as opportunists who would over-treat whenever they had the chance and therefore could not be trusted to look after the benefit manager's concern for controlling costs. While not totally without merit, it did cast aspersions on mental health providers generally, while the actual abuses were concentrated among a small percentage. Unfortunately, what has followed under the guise of managing care is an array of systematic abuses that are very wide-spread and adversely affect millions of people needing care, thousands of employers who pay for it, and the overall cost of health care in this country.

Without defending the old system, when a few patients were given more care than necessary, the problem was essentially one of financial waste. But, when the sickest of patients, whose conditions have ramifications far beyond the immediate issue of behavioral health costs, systematically receive inadequate care, the result not only increases costs of care but it also increases human suffering and liability exposure. In

essence, inadequate care, while cheaper at the moment, is much more expensive in the near future and can put people’s lives at risk.