Research Works

Partnership for Workplace Mental Health

Volume 1, Issue 3 December 2009

Successful Employer Implementation of the Federal Mental Health Parity and Addiction Equity Act

The Issue and Why It Is Important to Business

This brief is designed to help employers with the implementation of the new mental health and substance use disorder parity federal law provisions. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires employers that offer mental health/addiction coverage to do so at parity to their offering of medical/surgical health care benefits. Group health plans sponsored by businesses with more than 50 employees are prohibited from offering separate limits for the number of covered days and visits or higher deductibles, copayments, and out-of-network charges for mental health/addiction coverage. The law applies to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, and other similar limits. The law takes effect for plan years beginning on or after October 3, 2009 – so for calendar year plans, the rules take effect January 1, 2010.

I. The Problem

A complete understanding of the parity requirements will not be realized until they are explicitly defined in regulatory guidance – which the federal government has yet to issue. The law directs the Secretary of Labor to issue guidance in conjunction with the Secretaries of Health and Human Services and Treasury by October 3, 2009. However, even though the federal government has failed to meet its deadline, employers must still be in compliance with the law. While awaiting regulatory guidance, there are a number of key issues that every employer should consider in order to achieve successful implementation.

Summary Points from Research Review

- Review of actuarial and retrospective research studies on parity's impact on costs.
- Three key employer action steps for successful implementation.
- Characteristics of employers with positive parity experiences.
- Literature Review on the Business Case for Parity **(Appendix A, p. 13)**
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About Research Works

Research Works is a series that reviews the research literature on specific workplace mental health topics. The intended audience is employers and those in the business community who can take action on the issues and resources identified in the brief.

About the Partnership

The Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, advances effective employer approaches to mental health by combining the knowledge and experience of the American Psychiatric Association and employer partners.

Learn more at www.workplacementalhealth.org or by calling 703-907-8561.

Brokers and health plans may find this document useful as they work with employers to implement the required plan design changes.

The parity law's passage requires material changes to most health plan benefit design. Concern has been expressed about the potential for increased costs resulting from the new requirements at a time when employers already face a troubled economy. However, research indicates that these changes should not result in material cost increases and that any increases will be more than offset by net gains from reductions in overall health and disability costs and improved worker productivity - especially if benefits and services are well designed.

According to consultants at Milliman, "Forward-thinking plans and employers may use this parity requirement as an opportunity to improve their approach to behavioral healthcare. Ample opportunities for such improvements certainly exist."[1] Employers are thus faced with the challenge – or opportunity - of how to best implement the law's provisions in ways that optimize value, control costs, and assure quality care. In short, how can valuable dollars be deployed in ways that facilitate cost-effective mental health care that will allow businesses to reap the economic rewards of increased productivity?

There is a compelling business case for effective treatment of mental health and substance use disorders. Access to quality mental health/addiction care - sometimes called behavioral health care - is essential because of the high prevalence of these conditions in the workplace and their impact on other health care costs and the corporate bottom line when left untreated. Thousands of clinical studies have shown a high degree of therapeutic effectiveness for mental health and substance use treatment and relapse prevention. There is solid evidence to support that businesses benefit from overall cost savings from medical and disability cost reduction and increased productivity when mental health/addiction treatment is provided. (See Appendix A for a literature

review of the business case for effective treatment of mental health and substance use disorders.)

Research Works Overview. The purpose of this brief is to outline the research basis for aligning mental health and addiction benefit designs in ways that increase value and quality of care. This brief begins with an examination of findings from actuarial and retrospective research studies on the impact of parity on benefit costs and other outcomes. The next section offers three key employer action steps for consideration. Then an analysis of themes and characteristics from employers with positive parity experience is offered. The brief's final section provides a listing of other relevant resources. This issue also contains appendices which offer additional information, including:

- Appendix A: Literature Review on the Business Case for Parity
- Appendix B: Law Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
- Appendix C: State-Level Data of the Parity Experience
- Appendix D: Employer Case Study Experiences with Parity

II. Answers From Research

Parity is not a new concept. Many organizations have experience with parity, including the U.S. federal government, 45 of the 50 states, and the majority (61%) of large private sector employers.[2] Thus, there is already credible data and an experience base to draw from with regard to the impact on health care costs and other outcomes. Reviewed first are several actuarial studies, then other studies that have used retrospective experience data from specific states, and we end with a review of the investigations of parity for benefits of all employees of the federal government.

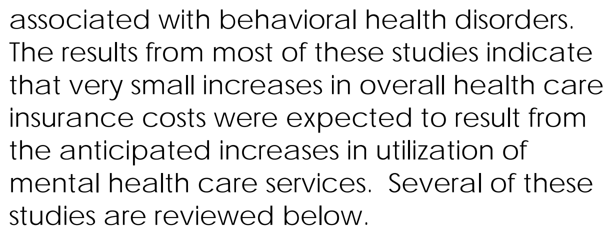
What Does Parity Cost?

The need for more appropriate access to mental health care is recognized by most in the business community. This was symbolized by broad support for the concept of parity, which helped enable its enactment into law. The parity bill that passed into law received support from both the business and insurance communities, with backers that included the U.S. Chamber of Commerce, the National Retail Federation, the American Benefits Council, and America's Health Insurance Plans.

A longstanding concern has been how to facilitate greater access to acute, short-term and long-term treatment services for mental health and substance abuse problems. The parity law provides benefits for services not provided currently in ways that reap the potential financial rewards that are possible through prevention and the delivery of high quality care. Indeed, according to actuarial benefits consultants at Milliman:

> The move to mental health parity coverage may well represent a great opportunity for positive change. An investment in more effective behavioral health care is an opportunity to improve not only mental health but also physical health in our insured populations. Such health improvements can lead not only to lower health care costs, but also to improved productivity among employees.[3]

Actuarial Studies of Parity. Actuarial studies have estimated the expected future financial cost impacts of parity law changed when such laws were first proposed. Such studies have the disadvantage of being prospective estimation exercises rather than retrospective analyses of real experience. However, the assumptions used in actuarial studies represent a type of professional meta-consensus about the potential impact of parity provisions given what is known at the time about clinical experience and research knowledge concerning the prevalence and costs



associated with behavioral health disorders. The results from most of these studies indicate that very small increases in overall health care insurance costs were expected to result from the anticipated increases in utilization of mental health care services. Several of these studies are reviewed below.

At the national level, the Congressional Budget Office's 2007 actuarial study of the proposed comprehensive parity legislation predicted it would increase premiums for group health insurance by an average of 0.16 percent (thus $1.60 for every $1,000).[4] A 2007 brief by Milliman had a similar conclusions, with a prediction that a parity law for mental health and substance abuse would have an increase of 0.6 percent of total health care premium cost annually without any managed care response and even less (0.1%) with a managed care response (thus between $1.00 and $6.00 for every $1,000).[5] Of note, these projections are underestimates of the net impact as they do not consider the potential cost offsets that may result from reduced demand for medical health services once behavioral health problems are treated.

At the state level, actuarial studies from California and Massachusetts both had similar findings to the national studies. A 2005 study on the effects of legislation proposing to expand the parity law in the state of California from only biologically-based conditions to comprehensive parity including all mental health conditions, estimated an increase of just 0.2 percent in total direct health care expenditures attributable to the bill.[6] A 2008 study for the state of Massachusetts also predicted small cost changes after parity, with an expected increase in overall health care costs for plans in the state in the range of 0.1 percent to 0.3 percent.[7]

In summary, the actuarial studies all estimated that total health care costs would increase minimally (most predicted a less than one quarter of one percent increase) with the increased availability of mental health and substance abuse services.

Retrospective Studies of State Parity Laws. Other studies have examined the real experience of various states in the U.S to compare changes in costs after parity was implemented. These studies examined changes in claims costs as well as other kinds of outcomes specific to the goals of the parity law, including the levels of awareness and stigma concerning these disorders, perceptions of access to care, and the rates of use of this kind of care (See Appendix C for brief summaries of studies of California, Minnesota, Ohio, North Carolina, and Vermont). The historical change data from states that have parity laws found that parity for mental health benefits (and substance abuse benefits in some studies) did *not* substantially increase utilization for mental health services nor did it increase overall health care costs. Thus, these findings reveal a positive experience with parity that included very small increases in health benefit costs.

Parity for Employees of the Federal Government. Perhaps the most rigorous research on the parity experience comes from several studies of the Federal Employees Health Benefits Program (FEHBP). FEHPB has had full parity for both mental health *and* substance abuse benefits since 2001. FEHBP is the largest employer-sponsored health benefits system in the United States, covering almost 9 million beneficiaries through more than 200 health plans. Evaluation of the FEHBP parity policy revealed that it increased adult beneficiaries' financial protection by lowering mental health and substance abuse out-of-pocket costs in most plans that have been studied and that it did not significantly increase rates of use for mental health services or the average total spending among adult service users as had been expected by critics of parity.[8] A 2007 study comparing longitudinal changes in claims data records for total health care costs and use rates at seven FEHBP health plans found small differences (less than 1%).[9] The conclusion from the study was that when coupled with appropriate managed care practices, implementation of parity in insurance benefits for behavioral health care improved insurance protection without increasing total costs.

The impact of parity on the FEHBP has also been studied for children and adolescents of covered employees. One study found that providing full mental health and substance abuse parity for children, within the context of managed care, achieved equivalence of benefits in health insurance coverage and reduced out-of-pocket costs for beneficiaries without adversely affecting the plan's total health care costs.[10] This study also found that parity did not increase use of these kinds of services for children – a finding shared by studies of parity at the state level.[11]

Bottom Line Results for Cost Impact of Parity. Taken together, the results from both actuarial and retrospective studies of past parity programs at the state and national levels consistently indicate that creating parity for mental health and substance abuse services has a negligible effect on overall health care costs in the short term. Examination of the findings from these sources yields an annual cost increase from parity laws in overall insurance premium costs of about one half of one percent (0.5%). An increase of this size translates into a very small cost impact – only an additional $24 per year per person, when 0.5 percent is applied to the $4,704 average cost of health care premiums paid by employers for single coverage employee health insurance benefits (based on a Kaiser study from 2008).[12]

III. Employer Action Steps

Based on the research evidence showing that parity yields significant clinical benefits without significantly increasing overall health care costs, the National Business Group on Health recommended in 2005 that employers should equalize their medical health and behavioral health employee benefit coverage.[13] While there are many way to accomplish this, the most effective employer approach to parity implementation includes three major tasks: (1) Structure and design benefits to comply with the law's requirements; (2) Manage the benefit to optimize quality and value at an appropriate cost; and (3) Ensure that the new benefit is integrated with related employer programs.

Step One: Structure and Design Benefits to Meet the Law's Requirements

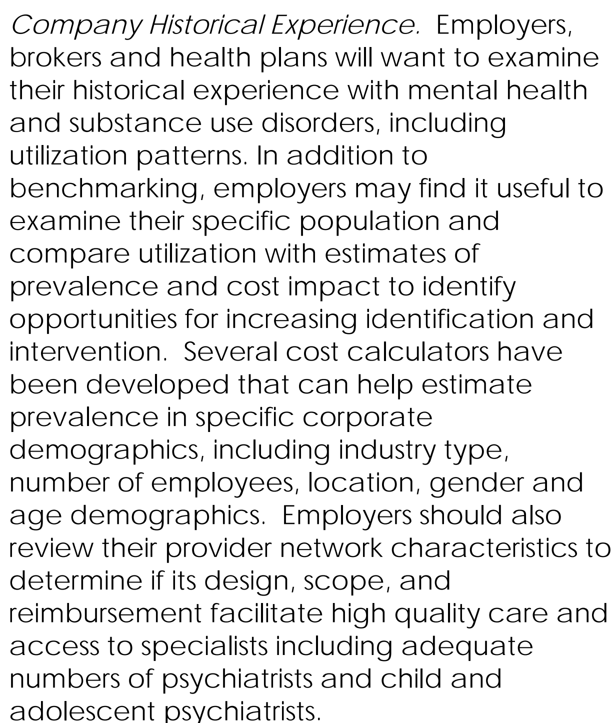
Employers, brokers and their health plans will have to carefully examine current benefit plans for medical/surgical and mental health and substance abuse treatment to determine what adjustments may be needed. In brief, the new parity law sets forth three major requirements for plan designs:

1. *Financial Requirements.* The parity law stipulates that financial requirements for mental health and substance abuse benefits covered under the plan be the same or better than the financial requirements for medical and surgical benefits under the plan. Financial requirements refer to plan features such as deductibles, co-payments, coinsurance, and maximum annual and lifetime out-of-pocket costs.

2. *Treatment Limitations.* The law prohibits treatment limitations (e.g., 30-day annual maximum for outpatient mental health treatment) for mental health and substance abuse benefits covered under the plan to the extent that medical and surgical treatments are not also limited.

3. *Out-of-Network Coverage.* The law requires that plans providing out-of-network coverage for medical and surgical benefits also provide out-of-network coverage for mental health and substance abuse benefits covered under the plan. It is estimated that 20 percent of such professional services for behavioral health nationally could be provided out-of-network.[14]

State Laws. Employers will also have to determine if state insurance laws are applicable to their organization. Descriptions of existing state parity laws which outline the type of law, affected policies and covered conditions are available online (see Resources Section of this brief for more information).



Company Historical Experience. Employers, brokers and health plans will want to examine their historical experience with mental health and substance use disorders, including utilization patterns. In addition to benchmarking, employers may find it useful to examine their specific population and compare utilization with estimates of prevalence and cost impact to identify opportunities for increasing identification and intervention. Several cost calculators have been developed that can help estimate prevalence in specific corporate demographics, including industry type, number of employees, location, gender and age demographics. Employers should also review their provider network characteristics to determine if its design, scope, and reimbursement facilitate high quality care and access to specialists including adequate numbers of psychiatrists and child and adolescent psychiatrists.

Step 2: Manage the Benefit to Optimize Quality and Value – Not Just to Cut Costs

Taking into account the high prevalence of mental illness and the presently low incidence of treatment, the question may not be how to control costs, but how to better deploy health care dollars in ways that ensure that the treatment of mental disorders are delivered more effectively and efficiently. Thus, the new parity requirements may present employers and health plans with an opportunity to increase access to quality care and realize a positive return on investment through increased productivity and decreased medical costs, absenteeism and disability. According to Milliman, "Plans and employers that have voluntarily offered this coverage, and those in states that have already required versions of parity, have demonstrated that careful benefit design and management can prevent runaway costs and offer better patient care at the same time."[3] There are multiple ways of approaching the benefit design and management process, but the literature suggests that efforts to restrict access to control costs have generally not been effective.

In order to achieve cost control, how tightly should benefits be managed? The law's intent is for health plans to retain their ability to manage benefits, and health plans are permitted to continue use of medical necessity criteria, utilization management and other care management techniques. However, employers and plans that aggressively restrict access to care with cumbersome prior authorization processes or overly aggressive management techniques may see costs increase in other more expensive ways. Open access to mental health treatment generally results in lower psychiatric disability claims and productivity losses compared to more restrictive plans. For instance, aggressive efforts to contain mental health care costs at one large corporation resulted in an expected decline of mental health services use and costs by more than one-third, but triggered an unexpected 37 percent increase in medical care use and sick leave wiping out any net savings.[15] It is important for employers and plans to also examine whether or not the administrative costs associated with employing such management techniques outweigh the claims savings.

Diagnostic Considerations. Coverage design issues also include questions about what mental health and substance abuse disorders to cover under the plan. The parity law does not require employers to cover all the diagnoses listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. However, selecting specific diagnoses to cover from the *DSM* is not recommended. The American Psychiatric Association (APA) recommends that employers and plans consider the severity and impairment of function rather than specific diagnoses for coverage decisions. Early identification, diagnosis, and intervention and treatment can pay for itself by avoiding costlier care such as emergency room and inpatient and avoiding short and long-term disability expense. The most important issue here is not the specific diagnoses, but the severity of symptoms, the impairment in function, and the specific type of treatment that is required. The APA recommends

focusing on medical necessity, because it makes more sense for coverage decisions to be driven by severity of symptom and functional impairment rather than diagnosis alone. With respect to this matter, the APA endorses the statement from the American Medical Association, which defines "medical necessity" as:

> … services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.[16]

Step 3: Ensure Integration With Related Medical Programs

Experts have suggested that the most reasoned approach to mental health parity may be to focus on improving quality of care and investing in efforts that integrate benefits and services – in part because of the recognition that mental and general medical conditions are frequently comorbid, that the preponderance of treatment for behavioral health disorders takes place in primary care settings, and that cost shifting occurs from the mental health to the medical benefit. A recent article in an in *Psychiatric Clinics of North America* stated,

> As long as mental health/substance use disorder remains segregated, costs for physical health services in patients who have mental health/substance use disorder will continue to shift from the behavioral health sector to the physical health sector. Moreover, costs will rise, and overall clinical improvement will be limited.[17]

The evidence suggests that integration can be effectively implemented. Integrated care for the treatment of depression that adds behavioral health care professionals to primary settings has been shown in 37 randomized controlled trials to significantly improve diagnostic accuracy, quality of care, and patient clinical outcomes.[18] As reported in *Medical Clinics of America*, when researchers compared integrated care models to other health care models, they found that the integrated care approach yielded better outcomes. The authors concluded, "...health system deficiencies will persist unless behavioral health services become an integral part of medical care (i.e., integrated). By doing so, it creates a win-win for virtually all parties involved."[19]
Employers have had success when their health plans support and their physicians provide integrated services in order to better identify conditions and to better support individuals earlier in the disease process. IBM is one example of this kind of success. IBM's Care Advocacy Model saved IBM over $500,000 in outpatient costs in just one year. This model integrated mental health, other medical illnesses, pharmacy, disability, disease management, as well as its employee assistance program. IBM has since expanded the Care Advocacy Model philosophy into an overall health care delivery model that focuses on behavior change.

Objectives for Integration of Services. Based on this evidence, it is essential that the overall benefit design and management approach to address parity include an effective medical/behavioral integration system. Whether mental health management is part of general medical management or "carved out" it must work in an integrative manner with the medical management system to:

- Identify medical cases that also have behavioral health comorbidities;
- Conduct quantitative assessments and regular monitoring of patient clinical status to determine the progress toward therapeutic improvement goals;
- Work with clinicians to make needed changes to the patient treatment plan

when there is evidence of no progress or relapse;

- Provide patient education and encourage activation in the self-care process; and
- Encourage PCPs to systematically refer and follow up.

The approach must also include methodologies that will have an impact on the effectiveness of behavioral health management practices provided by primary care physicians (PCPs), including:

- Identification of behavioral health cases within a PCP practice;
- Effective tracking of medical provider patterns to change their behavior toward screening and care targets;
- Making available effective practice support tools for PCPs that fit into their regular flow of office management activities;
- Wraparound behavioral health case management services and easy access to mental health providers to support PCP management; and
- Education of PCPs around support services available to their patients through their workplace including behavioral health support through their EAP.

Although the parity law does not require the integration of care, an issue has arisen about how specific provisions of the law may affect administrative payment processes that currently enable the disorganized and disintegrated approach to care. A question remains with respect to deductibles and annual lifetime limits: Are they permitted to be separate but equal under the new law? Regulatory guidance may prohibit separate but equal deductible and annual and lifetime limits. Mercer consultant's Traw and Bergner explained, "Because separate cost-sharing will no longer be permitted, regulators may determine that benefit costs must be applied to a single deductible covering medical/surgical benefits as well as mental health and substance abuse benefits. In this event, if mental health or substance abuse benefits are carved out, the carve-out and medical plan vendors will have to coordinate to make sure that all costs accumulate toward the shared deductible."[20] Beginning to align payment administrative practices to track real-time costs towards deductibles and annual limits could help facilitate care coordination and communication among providers.

Similarly, researchers at Milliman recently wrote, "Those that can achieve and document measurable savings through integrated medical-behavioral care management may gain a market advantage through lower health care costs, lower employer costs, and improved clinical outcomes."[21] In another paper, a return on investment of up to 2.5 was expected to occur from programs such as health plan payments for behavioral health screenings completed in primary care settings, onsite assistance from behavioral specialists, integrated medical-behavioral care management by nurses employed by health plans, and real-time video/teleconferencing with behavioral specialists.[3]

Employers have also had success when they have integrated programs, benefits and services in related areas and communicated them well to their employees, such as:

- Employee Assistance Programs (EAP)
- Screening for mental health and substance use
- Health Risk Appraisals (HRAs)
- Health promotion and wellness
- Family Medical Leave Act (FMLA)
- Absence management
- Employee education

- Case management
- Disease management
- Disability management (both short and long term)
- Caregiver programs

The Partnership for Workplace Mental Health website has an online database of over three dozen employer case examples, many of which focus on integration efforts in this regard. Visit www.workplacementalhealth.org to learn more.

IV. Employer Approaches

Employer Case Studies found in Appendix D

Employer case study examples of parity are presented in Appendix D. Eight different organizations from a variety of sectors are profiled, including: DuPont, The Houston Chronicle, The Houston Texans, JPMorgan Chase, Pitney Bowes, Polk County, Florida, State of Ohio, and Weingarten Realty Investors. Several themes recur among the examples of leading employers.

- Equalizing benefits is a good fit with the company's workplace culture and/or company leadership values. Leaders visibly support mental health care.
- Features of enhanced health management are frequently implemented concurrently with parity. These include cost control (case management), quality improvement (integrated benefits, coordinated care), and/or enhanced consumer involvement (early identification, enhanced communication with employees and family members about benefits, and enhanced support for mental health conditions).
- Those who have offered strong mental health benefits tend to provide them in the context of proactive and integrated health and wellness programs or other employee-centered programs, such as work/life balance initiatives or safety programs.
- Employers assess a wide variety of outcome measures, including total health care costs, employee engagement and satisfaction, attendance, and work performance.

Conclusion

Most employers understand that employee health and organizational performance are inextricably linked and recognize the importance of mental health in the overall well being of their workforce. The need for greater support for mental health and addiction disorders is profound and based on decades of solid research. All of the national level research studies of parity show the same general pattern of increased awareness of mental health and addiction services, appropriate increased use of outpatient mental health and addiction care services for mild to moderate severity cases, little to no impact on use patterns among more severe cases, only small cost increases or decreases in use of outpatient mental health and addictions care providers, and little or no impact on overall cost trend following parity implementation. Thus, the evidence from over twenty studies consistently indicates that creating parity for mental health and addiction services will have a very modest effect on costs for mental health care in the short-term. As a bonus, the requirements of the parity act may encourage practical methods to engage and treat the whole person – mind and body – in a comprehensive approach. These more integrated practices have the potential for returning significant net cost savings for the entire health care system. For employers to fully benefit from parity related gains, though, they must make considerations in benefit design that facilitates both greater access to care and higher quality care.

V. Resources

American Psychological Association. *An Employer's Guide to the Mental Health Parity and Addiction Equity Act / Wellstone-Domenici Parity Act (2009)*. This 6-page paper includes a general review of the law and features employer best practices for implementing parity and also provides answers to frequently asked questions regarding parity. www.phwa.org/assets/general/parity_law_employers_guide.pdf

American Psychological Association - Practice Organization. This website provides references and weblinks to many documents related to mental health parity. The links are organized into five categories: The integration of mental health and medical care; medical cost offset; government reports and actuarial studies; testimony in legislatures; fact sheets and press releases; and substance abuse parity. www.apapractice.org/apo/pracorg/legislative/mental_health_parity.html#

Milliman Consulting. *Preparing for Parity: Investing in Mental Health (2009)*. This 4-page paper outlines some steps that health plans should take to prepare for parity as well as to present parity as a possible opportunity to invest in mental health. www.milliman.com/expertise/healthcare/publications/rr/pdfs/preparing-parity-investing-mental-WP05-01-09.pdf

National Conference of State Legislators. *State Laws Mandating or Regulating Mental Health Benefits (2009)*. This web site provides information on existing sate parity laws and describes the specific illnesses covered, the type of benefit, and copays and coinsurance requirements. www.ncsl.org/IssuesResearch/Health/StateLawsMandatingorRegulatingMentalHealthB/tabid/14352/Default.aspx

Optum Health. *Federal Mental Health Parity A Legislative Summary: What You Need to Know (2009).* This 6-page brief provides a summary of the new law, who it affects, who is exempt, and how the law interacts with state law. www.optumhealth.com/content/File/OHBS_MentalHealthParity_June09.pdf

Partnership for Workplace Mental Health. *Mental Health Works* special issue on parity (Q1/Q2 2009). This 12-page newsletter includes case examples from employers with experience offering plans with parity benefit designs and includes an outline of the law and corporate reactions to the law. www.workplacementalhealth.org/pdf/MHW_Q1209.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). This government-sponsored website page provides an annotated bibliography of reports and materials related to behavioral health insurance parity. www.mentalhealth.samhsa.gov/cmhs/ManagedCare/Parity/Bibliography.asp

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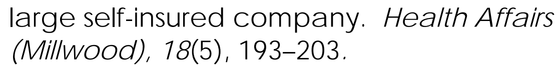

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VII. Appendices

Appendix A: Literature Review on the Business Case for Parity

There is a compelling business case for effective treatment of mental health and substance use disorders. Access to quality mental health/addiction care - sometimes called behavioral health care - is essential because of the high prevalence of these conditions in the workplace and their impact on other health care costs and the corporate bottom line when left untreated. Thousands of clinical studies have shown a high degree of therapeutic effectiveness for mental health and substance use treatment and relapse prevention. There is solid evidence to support that businesses benefit from overall cost savings from medical and disability cost reduction and increased productivity when mental health/addiction treatment is provided.

Mental Health and Substance Use Disorders are Prevalent in the Workforce

In the United States, 30 to 40 percent of the population experience mental health and substance use disorders at some point in their lives, with about half of these people (15% to 20%) requiring professional care each year.[1,2] Close to ten percent of workers are classified as "heavy alcohol users" who drink large amounts of alcohol on a regular basis.[3,4] The general prevalence of illicit drug use among U.S. workers is eight percent.[5] There is also significant co-occurrence of mental disorders and substance disorders (up to 25%) and significant co-occurrence of mental and substance use disorders with other chronic medical conditions.[4] Unlike most other costly health conditions, mental health and substance abuse disorders typically first take hold in adolescence or young adulthood and thus affect people in the prime of their working years.[6]

Most People Do Not Receive Adequate Treatment

According to national epidemiologic surveys in the U.S., the majority (about two-thirds) of people with symptoms of clinical criteria for having mental and substance use disorders do *not* receive any treatment at all for their condition.[7,8] This is related to many complex factors, including those related to the individual, physicians and the healthcare system. On the individual level, pervasive social stigma and lack of awareness of resources and their effectiveness often keeps those in need from seeking care. On the physician level, there is a lack of training and support for primary care physicians about these issues and a lack of education about the availability of workplace-based support systems. On the system level, there are inadequate funding mechanisms, a shortage of behavioral health care providers, and - most relevant to parity - inadequate or absence of insurance to pay for the care that is needed.[9] This unmet need is not limited to the uninsured, as one study showed that almost half of individuals in need of substance abuse treatment had private insurance.[10] Furthermore, most people with mental health or addiction disorders delay seeking professional treatment for many years (10 years of more), during which time they are likely to develop additional problems.[11] Once they do seek treatment, the number of visits allowed each year under many current mental health benefit plans may not be sufficient for effective treatment of a chronic disorder. These kinds of limits do not exist for treating other chronic conditions, such as cancer, diabetes, or heart disease, under general medical plans.

Impact on Business

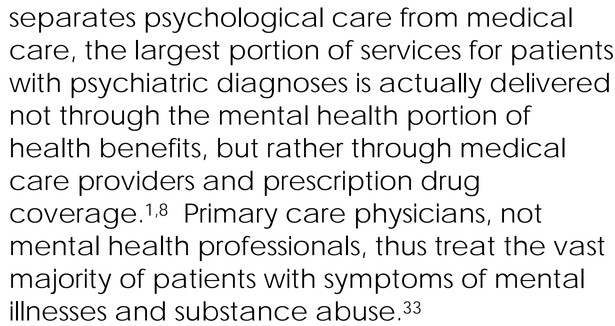
There is a clear business case to be made for improving early identification and intervention to increase care for those with mental health and substance disorders who need it.[12,13] Individuals who don't get treatment are costly to businesses because of their workplace

productivity deficits and because of their increased use of medical services. Employers have long recognized the need for providing access to quality mental health care. According to the Society of Human Resource Management's most recent benefits survey in 2009, 80 percent of employers in the U.S. sponsor mental health benefits coverage.[14] Employers provide these benefits in recognition of the tremendous impact that mental health and substance use disorders have on the workforce and on the company's bottom line. This impact extends well beyond the direct costs for mental health care treatment, which are often only a small fraction of total health care benefit costs (often between 3% to 5%). Instead, employers incur considerable costs from mental health conditions in other areas, including the medical and prescription portions of health benefits and in short and long term disability costs. However, the place where employers really feel the cost of mental illness tends to be in an area that is harder to measure: Indirect costs. Indeed, a decade's worth of studies have carefully examined employer data for multiple kinds of costs and have found that the preponderance of expenditures (typically over 70%) associated with mental illness and substance abuse disorders are found not in medical and pharmacy claims costs but instead in the indirect costs of employee absenteeism, presenteeism (i.e., when people are at work but not fully productive), turnover, and training costs for replaced workers.[15,16,17,18,19]

The Impact on Employee Work Productivity and Performance. Mental illness and substance abuse annually cost employers an estimated $80 to $100 billion in indirect costs alone.[20] More days of work loss and work impairment are caused by mental illness than by other chronic health conditions, including arthritis, asthma, back pain, diabetes, hypertension and heart disease.[21,22,23] In particular, employees with depression cost employers an estimated $44 billion per year in lost productive time.[24] Even employees with light to moderate alcohol use (e.g., binge drinking or hazardous drinking) can have high rates of absenteeism, tardiness, and poor work quality.[5] Studies have shown that substance-abusing employees function at about two thirds of their capability and that employees who use drugs are three times more likely to be late for work.[25] An estimated 500 million workdays are lost annually due to alcohol abuse.[25] Employees who use drugs are twice as likely to request early dismissal or time off and are two and a half times more likely to have absences of eight days or more.[25]

Impact on Disability. People with chronic medical illnesses with co-occurring mental health conditions make up a considerable portion of disability caseloads and mental health diagnoses are the fastest growing area of short-term disability claims.[26,27] Mental illness short-term disability claims are growing by 10 percent annually and can account for 30 percent or more of the disability burden for the typical employer.[24] Fifty-three percent of employers surveyed by Watson Wyatt found that return to work is more difficult for employees following an absence for a psychiatric disability than after an absence for a general medical disability.[28] Frequently employees have exhausted their mental health benefits making return to work all the more difficult. Fortunately, research indicates that disability costs related to mental health and substance problems can be reduced substantially when appropriate access to early intervention and treatment is provided.[29]

Impact on Overall Health care Costs. People with substance use disorders have overall health care costs that are more than twice as high per year than people without these disorders, and those with both substance abuse and mental disorders have costs that are even higher.[21,30] Driving this high cost scenario are a general lack of clinical recognition, frequent medical misdiagnosis, and profound under treatment of mental health and substance abuse disorders.[1] Less than half of all patients who see a medical doctor at a health clinic or in a primary care setting are screened for mental health problems of for alcohol/drug use,[31]even though validated and inexpensive brief screening tools are available.[32] Due to the fragmented health care system in the U.S. that



separates psychological care from medical care, the largest portion of services for patients with psychiatric diagnoses is actually delivered not through the mental health portion of health benefits, but rather through medical care providers and prescription drug coverage.[1,8] Primary care physicians, not mental health professionals, thus treat the vast majority of patients with symptoms of mental illnesses and substance abuse.[33]

Unfortunately, the quality of the care delivered by primary care physicians often is simply inadequate or inappropriate and usually does not conform to evidence-based clinical practice guidelines for mental health treatment.[34] Indeed, one study found that only 1 in every 8 patients with depression who were treated in primary care settings received even "minimally adequate care."[33] A lack of appropriate treatment is also found among the more complicated cases that suffer from both a mental disorder and from substance abuse (which is about a third of all people with a mental disorder). For example, among those with dual disorders, less than 1 in 10 cases receive treatment for both kinds of problems at the same time and this undertreatment can greatly extend the time until recovery is achieved.[4]

One of the most common examples of inadequate treatment for people with mental health problems is that when seeking care in medical settings, patients all too often receive medication alone, rather than medication in combination with evidence-based psychological treatment.[35] Analysis of prescription drug utilization data indicates that most antidepressant prescriptions are written by general practitioners.[36] Fewer than half of all patients who receive an antidepressant prescription ever refill their prescription. Further, more than two-thirds of patients discontinue treatment within three months of starting medication therapy.[37] This is highly problematic because most episodes of depression last 16 weeks and antidepressant medications generally take between four to six weeks to reach a therapeutic level.

Comorbidity with Other Chronic Medical Conditions. Also of importance is the frequent comorbidity of mental health and substance use disorders with other chronic illnesses. For example, 45 percent of people with asthma and 27 percent of people with diabetes have co-occurring depression.[38] Individuals with depression are also about twice as likely to develop coronary artery disease, twice as likely to have a stroke, and more than four times as likely to die within six months following a heart attack.[39] Many chronic medical conditions are adversely affected by mental health and substance abuse conditions. This comorbidity increases impairment in functioning and decreases adherence to prescribed regimens for treatment of medical conditions. For example, depressed patients are three times more likely to be non-compliant with their medical care treatment plan.[40]

Comorbidity can also drive up unnecessary utilization of health care services and overall health care treatment costs. People who have both chronic medical conditions and psychiatric conditions are far more likely to visit primary care physicians and emergency departments and to be hospitalized than people with medical conditions who do not also have mental disorders.[41] Indeed, 40 percent or more of hospitalized patients have some form of mental health of substance problem.[42] People with diabetes and depression have four times the health care expenditures as those with diabetes alone.[43] One study showed that depression and stress were actually more strongly linked to higher medical expenditures than were smoking and lack of exercise.[44] Authors of an article in *Psychiatric Clinics of North America* stated: "Illness in no other discipline is as prevalent as or has more impact on outcomes than psychiatric illness in the general medical setting."[45]

Treatment Works

Thousands of clinical studies have shown a high degree of therapeutic effectiveness for mental health and substance use treatment and relapse prevention.

Mental Health Treatment. The majority (65% to 80%) of individuals with mental disorders will improve with appropriate diagnosis, treatment, and ongoing monitoring.[1,46,47] This success rate exceeds that found for many current common medical treatments for non-psychiatric illnesses. Cognitive behavior therapy (CBT) and interpersonal therapy are consistently helpful in treating patients with the most commonly experienced mental health problems of anxiety, mild depression, and panic disorders. For more severe or chronic disorders (e.g., major depression, bipolar mood disorder, schizophrenia) the use of prescription medication treatments also can be successful, particularly when delivered in combination with counseling. National surveys of the users of mental health care services in the U.S. also have found that treatment is helpful from the patient perspective for the vast majority (over 80%) of people with mental disorders.[48]

Substance Abuse Treatment. Scientific reviews from around the world have found evidence that there are many effective approaches to alcohol and drug addiction treatment, such as self-help and support groups, counseling, residential programs, and use of medications.[49,50,51,52] National surveys from 2006 and 2007 in the U.S. found that 46 percent of self-help group participants for alcohol use were able to stop drinking, 33 percent of those in groups for illicit drug use were able to stop using, and 53 percent of participants in groups for using both alcohol and drug use were able to quit using.[53] The long-term success of treatments for those with severe forms of substance abuse, however, varies widely, with only a third to half of those receiving treatment being able to quit or substantially reduce their problematic use for more than a few years.[54] Some studies show that up to 70 percent of patients who are treated for substance dependence eventually recover.[55] However, the pattern of frequent relapse associated with serious alcohol and drug abuse once it progressed to an addiction is so common that it has led to the view among most treatment professionals that substance abuse should be considered a *chronic medical condition*.[49,50,56] The implication of this evidence-based view includes shifting the focus from treatment toward a more preventive strategy that encourages early identification and interventions with problem drinkers and substance users before more serious addiction can develop.[57,58] In addition, there are also some promising new developments in the area of pharmacological treatment for addictions.

Cost-Benefit of Treatment

There is a clear cost benefit for the treatment of mental and addiction disorders, due in part to the their high prevalence and cost enormous impact to business, but also because of the effectiveness of treatment. Over a dozen critical reviews and meta-analyses have been conducted in the last 25 years to examine the cost-benefit question. This body of knowledge provides substantial evidence that providing mental health treatment offsets or reduces the subsequent use of medical care services and their associated health care and disability costs.[59,60,61,62,63,64,65,66,67,68]

Research also documents even greater savings from providing appropriate treatment of mental disorders and addictions can come in the areas of indirect costs: Employee productivity, absenteeism, speed and quality of return to work after disability, and reduced turnover [69,70,71,72,73,74,75] One study found that antidepressant medication treatment for depression resulted in improved workplace productivity for over 80 percent of cases.[76] Similarly, Screening and Brief Intervention, Referral and Treatment (SBIRT), which is a technique combining the use of validated screening instruments and short-term intervention to reduce or eliminate harmful alcohol use, has been shown in initial tests to have a positive return on investment.[77]

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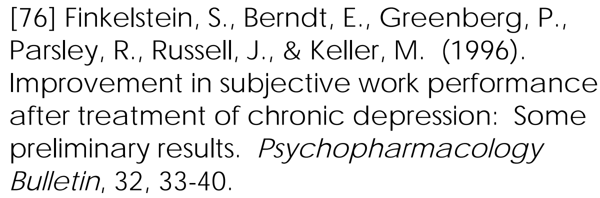

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Appendix B: Law Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (PL 110-343) was signed into law on October 3, 2008. The law provides parity between medical/surgical and mental health/addiction benefits in for plans that offer mental health/addiction coverage. Group health plans sponsored by businesses with more than 50 employees will be prohibited from imposing higher deductibles, co pays, and out-of-network charges for mental health/addiction coverage. The law builds on the 1996 law, which provided parity with respect to lifetime and annual dollar limits for mental illnesses but not substance use disorders.

The law applies to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits. Plans offering out of network coverage for medical/surgical benefits must provide out-of-network coverage for mental health/addiction benefits at parity. The law requires that certain information be disclosed when requested, including medical necessity criteria and reasons for a claims denial.

The law applies to plans beginning in the first plan coverage year that is one year after the date of enactment. For most plans, this will mean the effective date begins on January 1, 2010. Plans maintained under collective bargaining agreements ratified before the enactment date are not subject to the Act until they terminate (or until January 1, 2009, if this is a later date).

It is estimated that the law will affect 113 million people across the country, including 82 million individuals enrolled in self-funded plans (regulated under ERISA, the Employee Retirement Income Security Act) not subject to state parity laws. As with the current 1996 Federal parity law, small employers of 50 or fewer employees are exempt from the requirements of the Act. State parity laws will continue to apply to these employers, as well as to individual plans.

The law provides a cost exemption provision. If a group health plan (or coverage) experiences an increase in actual total costs with respect to medical/surgical and mental health/substance use benefits of 1 percent (2% in the first plan year that the law is applicable), the plan can be exempted from the law. Plans may only opt out for one year, and may be under audit by the Department of Health and Human Services, the Department of Labor, and actuarial analysis to assure transparency.

The current HIPAA preemption standard applies. This standard is extremely protective of State law. Only a State law that "prevents the application" of this Act will be preempted which means that stronger State parity and other consumer protection laws remain in place. In this way, the federal law is said to provide a "floor."

Appendix C: State-Level Data of the Parity Experience

The experience across more than 45 states that have parity laws supports actuarial projections that behavioral health parity would not substantially increase utilization or cost. The US government prepared a thorough evaluation of the initial impact of the 1996 federal parity law by examining changes experienced at the state level.[1] The findings from this report were that: Most state parity laws are limited in scope or application; State parity laws have had a small effect on premiums; Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees; and that costs for mental health/substance use disorders services have not shifted from the public to the private sector.

Below are some examples of this research.

Ohio. An early study from 1998 examined the utilization and cost effects of parity and managed care in a pre-post design with a multiyear follow-up period. Ohio provides an unusually long time period of seven years of managed behavioral health benefits in the 1990s. The switch from unmanaged indemnity care to managed carve-out care was followed by a 75 percent drop in mental health inpatient days and a 40 percent drop in mental health outpatient visits per 1000 members, despite the simultaneous increase in the availability of benefits. The subsequent years saw a continuous decline in inpatient days and an increased use of intermediate services, such as residential care and intensive outpatient care.[2]

North Carolina. In North Carolina, a study from 2000 found that mental health expenses decreased every year since comprehensive parity for state and local employees was passed in 1992.[3] More specifically, mental health costs, as a percentage of total health benefits, decreased from 6.4 percent in 1992 to 3.1 percent in 1998, and mental health hospital days were reduced by 70 percent since 1992.

Vermont. A 2003 study by the Substance Abuse and Mental Health Services Administration found that Vermont's parity law was effective in controlling costs.[4] Vermont implemented the nation's most comprehensive parity law in 1998, requiring insurance companies to provide coverage for mental health services equal to general medical health coverage. In the first two years after the parity law took effect, mental health and addiction treatment spending in Vermont dropped by a range of 8 percent to 18 percent, depending on the health plan studied. Employers in Vermont tended not to drop coverage or switch to self-insured plans. Of the employers offering insurance coverage when parity went into effect, only 0.3 percent reported dropping coverage due to parity and only 3 percent of employers switched one or more of their health plans to a self-insured product citing parity as a factor. Health plan spending rose slightly or declined due to parity, depending on the particular health plan. Consumer cost-sharing for covered mental health and substance abuse services fell from 27 percent to 16 percent of total spending.

Minnesota. Blue Cross and Blue Shield of Minnesota, which covers more than two-thirds of the population in the state, was able to reduce its insurance premiums by five percent after one year's experience under the state's comprehensive mental health parity law in 1995 that included mental health and substance abuse.[3] Cost increases in overall health care insurance premiums due to the parity law were small - only 1 percent to 2 percent.

California. California's parity legislation is similar to the 2008 federal Act in that it prohibits insurers from setting limits on treatment and services that are more restrictive than those for general medical care and also prohibits insurers from requiring higher copayments than those for general medical care. However, it restricts parity benefits for adults to only those with *severe* mental disorders. A 2002 study compared the mental health claims use and costs for two large employers in California for periods before and

after the parity law.[5] The study findings revealed that plans with high costs and high service use showed stable or declining spending after parity and that the lower-cost plans showed only small increases of less than 1 percent of total costs. A more recent study from 2009[6] interviewed health care experts at the state and private industry level about the experiences in years 2000 to 2005 in the state of California. The results indicated that implementation of the 2008 federal parity law should include monitoring health plan performance related to access and quality, in addition to monitoring coverage and costs; examining the breadth of diagnoses covered by health plans; and mounting a campaign to educate consumers about their insurance benefits. Limiting the application of the law to only diagnosis of certain psychiatric conditions was found to have generated several unanticipated negative consequences and was not recommended for other contexts.

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Appendix D: Employer Case Study Experiences with Parity

When Parity Means "Business as Usual"

By Nancy Spangler, M.S., OTR/L
Source: Mental HealthWorks Newsletter (Q1/Q2 2009)

Adapting to changes in mental health parity legislation may be a challenge for some employers, but to others, parity is not terribly new. In fact, a number of US workplaces have been offering mental health benefits on par with their medical plans, or very close to it, for many years. In some cases, their mental health coverage is even better than their medical coverage (i.e., co-payments or cost-sharing are lower for mental health than for medical/surgical treatment).

The Partnership for Workplace Mental Health talked with several employers to learn more about their experiences with offering strong mental health benefits and the impact that this has had on their organizations. (Read about these employers and others in the Partnership's database, *Employer Innovations Online* at www.workplacementalhealth.org/search.aspx

Weingarten Realty Investors

In the Houston area, a number of employers began a move toward parity in 2002 through the leadership and encouragement of Stanford Alexander, Chairman of Weingarten Realty Investors. Weingarten is a self-insured Fortune 500 firm with more than 400 employees in 23 states.

Alexander's family was touched by mental illness, and when he learned that a number of his employees who had mental conditions were not seeking the professional help they needed due to limitations of medical coverage, he was determined to do something about it.

Weingarten's plan includes coverage for alcohol and substance abuse and for treatment of family/marital problems. There are no caps on mental health treatment, and deductibles are the same as they are for general medical treatments. Mickey Townsell, Vice President of the company's Human Resources, says that Weingarten budgets about $10,000 per employee per year for benefits. Mental health represents approximately 1.5 percent of annual benefit costs.

"Every company is obviously looking for ways to reduce costs, but with all the demands we have to deal with in this day and age, you have to see what you can do to help employees," says Townsell. Assisting the company's employees, which Weingarten considers its "key assets," adds value long term. Here is just one example of how this program paid off for Weingarten.

An employee, who had been with the company for 15 years, was struggling with a mental health issue and took a leave of absence. Access to professional care helped this employee work things through, and he was able to return to work. "You don't want to lose those long-standing employees or their family members if you can help them," Townsell stated. "Getting them the care they need may help the employee's overall ability to be at work."

Weingarten assesses the results in a number of ways. "Yes, you can look at turnover—and our turnover is about half of the industry standard—that's a meaningful measure. But peace of mind is immeasurable. Employees being more productive, more thankful to the organization: Those are meaningful outcomes that are not easy to quantify."

Townsell says that Alexander treats employees like family. Parity was another step toward giving people the help they need. Alexander values and develops good leaders. Senior managers have grown up together, many for 20 years or more. That gives the leadership team comfort with each other. "Employees here want to do a good job for these leaders; they have a sense of pride in this organization," says Townsell. "People work hard, they know what they need to do—but at the same time family is highly valued. If I need

to leave early to get to my son's game, I know that's all right."

Alexander has served on several hospital boards and will contact the hospital himself to use his influence on behalf of an employee or family member if needed. Employees know that they can count on him to help in many ways. They all call Weingarten a family-owned, publicly traded company.

Houston Chronicle

After Weingarten Realty Investors set the stage for mental health parity, a number of other Houston employers joined in, including the *Houston Chronic*le and the Houston Texans (featured in *Mental HealthWorks*, 4th Quarter, 2008).

The *Chronicle* employees 1,400 people in the Houston area and is led by Jack Sweeney, President and Publisher. Their organization is self-insured. In 2002, the *Chronicle* implemented mental health parity and increased promotion of their EAP, which provided 24-hour access to mental health support and three in-person visits at no cost.

The *Chronicle's* total health care costs remained flat, and Sweeney reports they experienced a number of additional benefits. The parity effort and increased attention on mental health has helped improve worker performance, enhanced communication between managers and employees, and reduced the stigma of accessing treatment. "It's a win-win for the company and the employees," he said. "People seek help earlier and get back to health and to work quicker if you show respect for their issues."

Just implementing parity is not enough, though. Sweeney suggests leaders need to set examples and address emotional issues right along with exercise and other general medical health issues. He also encourages employers to think of the work performance side, not simply direct costs, when evaluating parity. "Emotional problems drive up health costs on the primary care side if you do not deal with them. Companies need to push for high quality, well coordinated care, and get their vendors to work together to address costs and cost drivers," says Sweeney.

Houston Texans

To implement mental health parity, the Texans sought an insurance carrier to work with them hand-in-hand designing a plan with co-pays and deductibles equal across behavioral and medical/surgical areas. To their surprise, carriers predicted their health care costs would increase 20 percent to 25 percent if they offered such generous coverage in behavioral health.

In 2002, the first year of operations for the Texans, parity was instituted. Cigna agreed to equalize the plans and charged 2 percent more than expected costs without parity with the understanding that additional charges would be added at the end of the year based on increased costs. Employees did use the mental health benefits, but total costs did *not* increase. The base rate and premiums stayed the same.

JPMorgan Chase

With headquarters in New York and Chicago, the JPMorgan Chase benefits crew is evaluating adjustments needed for parity for their many different medical and behavioral health plans across the country. The behavioral health plans covering their 140,000 US-based employees are strong, and although most plans already meet parity requirements, all must be reviewed to ensure agreement with the measure. The complexity of plan designs makes the revision challenging for large employers with many locations.

Daniel J. Conti, Ph.D., Managing Director of EAP & Work-Life for JPMorgan Chase, says, "Really, the message of parity is old news to us—we've known for a long time that good mental health coverage is critical to businesses. What employers should know is that psychiatric illness has a profound impact on work. This is not speculation. There is strong research showing that psychiatric illnesses drive more disability and longer periods of

disability ... so it would only make sense that a corporate-sponsored health plan would pay close attention to mental health."

Pitney Bowes

J. Brent Pawlecki, M.D., Corporate Medical Director of Pitney Bowes, told *Mental HealthWorks* that Pitney Bowes has had parity for many years, and "we don't expect to have to make many changes" to comply with the new law. He noted that Pitney Bowes has worked hard over the years to create a "culture of health," which is tied to mental health. "We don't separate mental health from physical health," he said.

Pawlecki emphasized that while some companies may look at each of their programs as a way to contain costs, Pitney Bowes tends to look at the entire culture of health and see quality health benefits as an investment in their employees.

The cornerstone of Pitney Bowes' approach to health care is the integration of value-based benefits and services. Even with good health benefits, though, Pitney Bowes' annual costs are rising at a substantially lower rate than the other companies it benchmarks against. "We believe these results are testimony to the return-on investment of our integrated approach to health and wellness," Pawlecki said.

To keep tabs on employee morale, Pitney Bowes uses an employee engagement measuring tool, which asks questions about how engaged employees are, how effective the leadership is, which benefits they value, and so on.

The leadership at Pitney Bowes believes that investment in the health of its employees has proven important for the overall success of the corporation, providing value for both its employees and shareholders.

DuPont

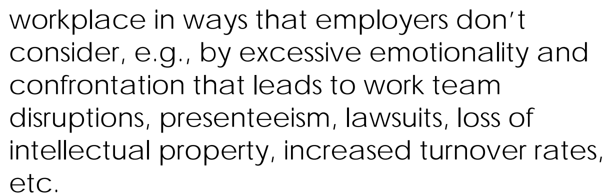
Paul Heck, EAP Director, shares that DuPont has had mental health parity since 1991. "In the US, DuPont pays 90 percent for any mental health treatment, up to $1.5 million per year, with no deductible as long as care is accessed through the EAP. This is *better* coverage than our medical/surgical plans, though the difference would depend upon which plan is chosen by the employee."

EAP referrals are required for all in-network treatment, from intensive outpatient therapy to certified alcohol/substance abuse counseling to inpatient care. EAP is not just a benefit but also a hands-on manager of quality of care. With an emphasis on improving quality of care, not just cost, DuPont developed a grid to guide EAP referrals to the right level of care, matching need to level of intervention.

In the 1990s when others were seeing 9 percent to 12 percent increases in overall health care costs, DuPont's increases were 0 percent to 3 percent. Recidivism from treatment was also lower than other employers. "We're still offering a robust EAP/behavioral health program because we've been able to justify that better management and quality of mental health care reduces total costs," Heck said. "This is very important to self-insured companies."

Integrating behavioral health also extends to disability management. DuPont's EAP coordinates psychiatric disability management, and the EAP is often involved as a consultant to the employee and the manager as workers go out on leave and as they return. "Our whole philosophy is that if a person is too sick to work, it is a personal crisis. Our model is based on managing disability, getting people back to work, and helping them return to better health. People self-actualize through positive work experiences."

Heck made the following recommendations. As employers implement mental health parity, they should think beyond simply improving mental health coverage—the effort has to be value-driven. Workplaces need to reduce financial barriers and stigma. People with mental health conditions that are unaddressed will often act out in the



workplace in ways that employers don't consider, e.g., by excessive emotionality and confrontation that leads to work team disruptions, presenteeism, lawsuits, loss of intellectual property, increased turnover rates, etc.

State of Ohio

The State of Ohio has had a joint labor management group for many years with equal representation from bargaining units, management, and union employees. The union drove the effort to equalize mental health and substance abuse benefits with their medical plans. In 1990, a behavioral health carve-out plan was initiated in one of the state's 17 health plans. Ohio was among the first states, and perhaps the very first, to include parity of substance abuse.

In 1990, behavioral health care expenditures for the 23,000 covered lives included in this plan dropped from $11 million in 1989 to $7 million.

Benefit manager Gary Hall was hired in 1990 to manage the transition to the new behavioral health vendor. At the time of his hire, Hall was working as a psychiatric nurse. He was able to use his clinical and health system skills when talking with employees who were concerned about having to switch from a current clinician to a clinician within the behavioral health network. To smooth the transition and to ensure proper coverage as the regional networks were developed, the vendor worked with employees on a case-by-case basis. In some cases, the vendor allowed employees 12 additional visits with their current clinician, and patients were allowed the right to nominate their clinicians for inclusion in the vendor's network, upon review of credentials. Hall also has a business degree and a background in human resources.

Hall says that before parity, coverage in some cases was too restrictive, but in other cases was overly generous and without accountability. Through the new plan, the state finally had some kind of handle on what their dollars were covering. Anecdotally, Hall feels the quality of behavioral health care improved as well through the concerted effort and attention. He says "Mental health parity is still saving us money."

In 1995, all mental health and substance abuse coverage came under one behavioral health plan managed by the vendor now operating as OptumHealth Behavioral Solutions. Coverage increased from 23,000 lives to 134,000 lives, yet costs only increased from $7.1 million in 1995 to $10.6 million in 1996. This is still less than what the state paid for 23,000 lives in 1989. Next year, the state will be moving to a self-insured plan.

Polk County, Florida

Before 2008, Polk County's carve-out plan for mental health and substance abuse treatment limited the number of hospital days or outpatient visits allowed. As the County analyzed chronic conditions among its employees and their dependents, they discovered that mental health problems were affecting people's ability to improve physically, and work abilities were declining. The County began implementing disease management programs, primarily for diabetes and hypertension, in 2005. They found tremendous value in the case management approach and in treating the whole person, not just a part of the problem. In addition, they determined that most mental health treatment is now being delivered in outpatient formats, and they felt their risk was low in moving to full parity for mental health coverage.

Risk Management Director Mike Kushner said that in January 2008 the County began working with Aetna for its EAP and behavioral health treatment. Aetna also became the third-party administrator for the County's self-funded general medical/surgical plan. There is now no distinction between mental health and medical visits. Although there are some elements of utilization management, such as focusing on outpatient care, there are no limits on hospital days or the number of psychological or psychiatric outpatient visits. The plan does cover treatment in residential

facilities for drug addiction and withdrawal, but the incidence of these cases has been greatly reduced.

The County's disease management approach removes several barriers to treating chronic conditions. For people with diabetes, for example, easier access to pharmacy services is provided by a clinical pharmacist onsite in their health clinic. To reduce financial barriers, all co-pays for treatment are waived, as long as participants routinely complete their hemoglobin A1C checks, eye examinations, and foot checks. All medications are covered at a 100 percent level, including those for common co-morbidities, such as depression, bipolar disorder, and hypertension.

Screening for depression is included in both the diabetes and hypertension management programs. Participants are referred to mental health professionals for psychotherapy as needed. Aetna has a "gap-in-care" approach that allows them to determine through claims analysis when adherence with treatment has dropped. Letters are then sent to the individual and to his or her physician to alert physicians to potential problems in discontinuing treatment.

In terms of costs, the County had expected to see mental health care utilization rise in the first year after parity, and it did increase slightly. Total health care costs, however, have not increased.

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