

COMPREHENSIVE
MENTAL HEALTH

INSURANCE
BENEFITS:
CASE STUDIES

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Disclaimer

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Executive Summary

This report focuses on in-depth case studies of six employers, two health maintenance organizations (HMOs), and one managed behavioral healthcare organization (MBHO) in an effort to provide clear and well-documented examples for other companies and managed care organizations (MCOs) to consider. The report reveals several key themes about comprehensive mental health benefits.

Employers

- Study participants voluntarily provide comprehensive mental health benefits based on
 - a belief that employee mental health is crucial to the company's success;
 - a recognition that mental health problems are common in the workforce, and that early intervention and continuing treatment can address such problems effectively;
 - a “common sense” rationale that investing in the mental health needs of their employees will produce long-term savings by decreasing health care costs, increasing productivity, and reducing absenteeism; and
 - an understanding that restricting mental health benefits may cause an increase in overall health care costs.
- All six employers invest significant resources in employee assistance programs (EAPs) that provide a wide range of services designed to increase access to care.
- One company offers mental health benefits at levels that exceed parity with physical health coverage. While none of the employers offers absolute parity between physical and mental health benefits, they do use alternative mechanisms to ensure comprehensive mental health care. Most companies exceed parity in some areas and fail to reach it in others.
- Employers recognize that unless employees access coverage, providing a comprehensive set of benefits is useless. In general, employers have developed cost-sharing structures that encourage employees to access mental health care, but also have placed more limits on extended use of outpatient psychiatric benefits than on physical health services of similar duration. They have implemented programs that fall outside the scope of traditional mental health services.
- Study participants offer comprehensive mental health benefits as part of a larger corporate culture that emphasizes investment in employees' overall wellness. Corporate leadership can help define this culture and can play a significant role in a company's decision to improve its mental health benefits.

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- All six employers use different techniques and arrangements to manage mental health benefits; no specific formula defines the management approach to provision of comprehensive benefits. All employers take an active role in direct management of both the plans and the vendors. Rather than accepting the status quo, these companies evaluate their plan options continuously.
 - The majority of employers did not use performance data to assess the effects of access to mental health care services on employee productivity and health care costs. Employers' decisions to provide comprehensive mental health benefits have been independent of such data. The employers rely heavily on employee feedback to shape benefit design.

Managed Care Organizations

- The HMOs and MBHO place high priority on integrating physical and mental health care services, as well as on maintaining open communication and coordination of care between mental health specialists and primary care physicians. All three organizations offer a wide range of services across the continuum of mental health care.
- The three MCOs, all of which are regional players, have felt the effects of recent trends toward consolidated and nationalized benefits. As more employers purchase benefits through national plans, regional vendors receive a decreasing share of private sector business. To remain competitive, they may need to alter their approach to providing regionally based products.
- Most of the performance data reported by the HMOs are Health Employer Data and Information Set (HEDIS) measures.

All three MCOs use member surveys to measure satisfaction, quality of care, cost of care, and access to services. They also monitor behavioral-health-specific measures.

A literature review and a discussion with an Advisory Panel revealed significant problems inherent in developing a specific quantitative methodology to identify companies with “generous” benefits. Companies were selected after an examination of factors related to the priority they place on employee mental health care. Thus, the selection process identified employers that provide a range of innovative and flexible mental health benefits and that encourage employees to use them. The final group of six employers largely is the product of extensive self-selection; of the companies identified, these six showed significant interest.

The selection process for MCOs focused on specific managed care models. Staff model HMOs represented the majority of plans that offer benefits extending beyond a basic menu of services; however, many HMOs have moved away from staff models and toward provider networks. Consequently, this study examines two HMOs with experience integrating both models. Furthermore, since many MCOs carve out mental health services to a specialty firm, this study also includes one MBHO.

After study participants were selected, interviews were conducted with employer representatives; the results were synthesized into individual case studies. These case studies discuss the mental health benefit options, benefit management, performance data and monitoring, motivation for providing comprehensive benefits, and lessons learned/challenges remaining.



Overview and Background

The Center for Mental Health Services sought to explore and document the experiences of, and lessons learned by, several employers and MCOs that offer comprehensive mental health coverage. This report provides indepth case studies of six employers, two HMOs, and one MBHO, resulting in several clear and well-documented examples for other companies and MCOs to consider. Although the majority of employers studied are large and self-insured, the findings have implications for smaller businesses that want to provide cost-effective, comprehensive care to a small workforce. This report discusses the methodology used to select participants and presents key findings distilled from the case studies.

Issues concerning employer-sponsored mental health care have made national headlines in recent years. Legislative efforts to mandate parity for physical and mental health care and to regulate MCOs have received extensive national publicity. At the same time, the relationship between productivity and mental health, most notably depression, has recently attracted scholarly attention. Each of these timely issues bears a relationship to new directions in employer-sponsored mental health benefits.

Private sector attitudes toward insurance coverage for mental health care have been transformed over the past 30 years. Long regarded as a State responsibility, mental health care increasingly was incorporated in private sector insurance coverage during the 1960s and 1970s as many employers came to believe that such coverage resulted in greater productivity. However, many of the expanded benefits failed to reach parity with physical

health coverage, containing special limits on hospital days and outpatient visits, higher copayments and coinsurance, and separate and lower annual lifetime limits on total payments. Many plans, including those offered by the Federal Government and some large corporations, provided relatively generous benefits by today's standards.

Rising health care costs in the late 1980s halted this expansion in coverage. Starting from a very low cost base, the new mental health benefits often appeared to be growing faster than other health care costs. For a variety of reasons, many employers began to identify mental health benefits as expendable, reducing them to realize short-term cost savings. As employers started the transition to managed care, they began by shifting their mental health benefits—a trend that continues today.

A Hay Group study analyzing trends in health plan design between 1988 and 1998

suggests the decade was marked by significant changes in the type and structure of employer-sponsored health insurance. In 1987, 92 percent of employers enrolled most of their employees in fee-for-service plans; by 1998, only 14 percent of employers reported fee-for-service as the most prevalent arrangement; the balance operated managed care plans (Hay Group, 1999).

Managed care's emphasis on cost reduction has resulted in growing limits on mental health care. In the 1998 study of managed care plans sponsored by 1,017 medium and large employers, 88 percent of plans, up from 63 percent in 1990, imposed limits on inpatient psychiatric care; for outpatient care, 57 percent of plans had utilization restrictions, compared with 26 percent in 1988. Furthermore, annual benefit caps had not kept pace with inflation; the average limit held at \$2,500 from 1988 to 1998.¹ In 1997, more than 75 percent of employer-sponsored health plans imposed greater limits on mental health treatments than on physical health care (Buck, Teich, Umland, & Stein, 1999).

An extensive body of literature suggests that increasing limits on mental health benefits, in fact, may not be a successful long-term strategy to reduce health care expenditures. American businesses lose an estimated \$43.7 billion every year to employee behavioral health problems. These estimates include losses from absenteeism, sick leave, substance abuse, health insurance claims, accidents, overtime pay, disability payments, damage to the corporate image, and diverted supervisor time (Vennoch, 1995). Many

studies reveal a high prevalence of mental health needs among the workforce. The following examples illustrate the relationship of mental health to medical claims costs and absenteeism as well as the larger link between mental health benefits and health care costs.

The Health Enhancement Research Organization (HERO) recently linked medical claims data to health risk appraisal information for 46,026 employees enrolled in fee-for-service, self-insured health care plans. Analysis of risk factors associated with health care claims revealed that depression and stress were the two most significant factors in increased claims expenditures. Individuals reporting persistent depression (2.2 percent of the sample) had health care costs 70 percent greater than other employees; those with uncontrolled stress (18 percent of the sample) had 46 percent greater expenditures. These two factors had a greater impact on total health care costs than did obesity, high blood pressure, high cholesterol, and tobacco use (Goetzel et al., 1998).

In addition to increased health care expenditures, depression also produces significantly more short-term disability absences. A recent study found that depressed workers miss between 1.5 and 3.2 more days for short-term disability than other workers. Furthermore, the study suggests that this increased absenteeism produces monthly salary-equivalent disability costs of \$182 to \$395 or between 45 and 98 percent of the estimated cost for effective depression pharmacotherapy (\$402). These figures exclude significant indirect costs, including expenses inherent in hiring and training new workers, decreased productivity of the employee and of coworkers, and increased incidence of workplace accidents (Kessler et al., 1999).

¹ Under the Federal Mental Health Parity Act of 1996, such disparities benefit limits now generally are prohibited for firms with more than 50 employees.

Few studies have examined the relationship between mental health benefits and overall health care spending, particularly the impact on overall cost levels of mental health coverage. A recent study of one large company, however, suggests that a decrease in mental health spending yields concomitant increases in total health expenditures and employee absences. In this study, increased physical health costs completely eliminated the savings generated by decreased mental health expenditures. As a result, the company experienced reduced mental health coverage and no associated financial benefit (Rosenheck, Druss, Stolar, Leslie, & Sledge, 1999).

These studies suggest that the trends toward increased limitations on psychiatric services and the resultant decreases in mental health expenditures may have limited effects on a firm's overall health care costs and, in fact, may have an adverse effect on the company's overall financial situation.

Many employers do not offer equal physical and mental health benefits because they believe the cost will prove prohibitive. This lack of parity has led governments, both Federal and State, to examine employer-sponsored health coverage. As of October 1999, 24 States had enacted mental health parity laws, and many others continue to consider such legislation (Hiebert-White, 1999).

Self-insured employers, such as the majority of study participants, are exempt from these restrictions because of the Employee Retirement Income Security Act. However, legislative mandates, including parity legislation and managed care reform, could have significant effects. A recent study suggests that parity legislation may result in premium increases between 3 and 11 percent, depend-

ing on plan type; indemnity and preferred provider organization (PPO) plans, characterized by more provider choice, would experience greater premium increases (Findlay, 1999). At the same time, mandates and competitive pressure to provide generous mental health benefits may lead to long-term cost savings for employers by fostering increased productivity, decreased absenteeism, and a decline in total health care costs.

Current State of Private Sector Mental Health Care

Managed care dominates the employer-sponsored health insurance market. According to the 1996 Foster Higgins survey of all U.S. employers with 10 or more employees, only 22 percent of eligible employees were enrolled in indemnity plans while the remaining 78 percent received coverage under managed care plans. Of all eligible employees, 30 percent enrolled in HMOs, 29 percent in PPOs, and 18 percent in point-of-service (POS) plans (Foster Higgins, 1997).²

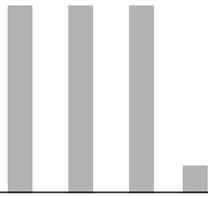
Many indemnity and managed care plans place significant limits on services. Plans frequently impose annual or lifetime benefit maximums or limits on days per year. Table 1 details inpatient and outpatient limits by plan.

In addition, while most plans cover inpatient and outpatient mental health care, many do not offer multiple levels of care. For example, only half of plans cover non-hospital residential psychiatric services. Plans appear to focus on traditional levels of care (inpatient, outpatient) and, in general, to place significant limitations on services.

² Figures for employers with more than 500 employees.

Table 1: Coverage Limitations, by Plan				
	<i>Indemnity</i>	<i>PPO</i>	<i>POS</i>	<i>HMO</i>
<i>Inpatient Limitations</i>				
Amount payable per year				
Percent of plans with limitation	36%	31%	16%	11%
Median amount of limit	\$10,000	\$10,000	\$10,000	\$10,000
Amount payable per lifetime				
Percent of plans with limitation	50%	56%	34%	8%
Median amount of limit	\$40,000	\$30,000	\$50,000	\$30,000
Number of days per year				
Percent of plans with limitation	40%	39%	56%	67%
Median amount of limit	30	30	30	30
<i>Outpatient Limitations</i>				
Amount payable per year				
Percent of plans with limitation	54%	49%	30%	11%
Median amount of limit	\$2,000	\$2,000	\$2,000	\$2,000
Amount payable per lifetime				
Percent of plans with limitation	39%	45%	28%	7%
Median amount of limit	\$40,000	\$25,000	\$50,000	\$30,000
Number of days per year				
Percent of plans with limitation	28%	27%	47%	67%
Median amount of limit	39	39	24	20

Source: Foster Higgins (1997).



Methodology

This report presents case studies and analyses of six employers and three MCOs that provide comprehensive mental health benefits. The key tasks in preparing the studies and analyses included

- identifying study participants;
- developing a survey instrument;
- conducting interviews;
- summarizing and analyzing findings; and
- collaborating with employers to ensure accuracy of results.

A literature review of major studies of comprehensive mental health and substance abuse insurance coverage provided the base for selecting participants and developing the survey instrument. This review included a case study synopsis for several employers that offer innovative behavioral health benefits and identified key topics for consideration in the report. The literature review also established a locus for discussion for an Advisory Panel (see Appendix A) convened to offer guidance. The panel, which included health care policy experts and representatives from the employer community and the insurance industry, provided advice concerning criteria for selecting case study subjects and identified types of information to be gathered.

Initially, a quantitative methodology was proposed to guide participant selection. Candidates were to be selected only if they met a minimum threshold of coverage, based on a review of publicly available data on specific

benefits. The existing literature, however, revealed that available data would be insufficient as the sole criteria for selecting employers. Specifically, determining an appropriate threshold proved difficult because almost all employers met the benefit standard. Furthermore, existing data did not accurately represent differences in benefits and did not offer the opportunity to examine innovative practices. For example, the type of case management offered by employers who reported having “case management” varied dramatically, yet the data did not portray those variations. The panel eventually helped make the decision to select employers and MCOs through less quantitative measures.

Criteria Involved in Employer Selection

Employer identification was approached through the Delphi method, in which expert nominations and referrals guide the selection process. The panel recommended employers and identified additional experts from whom to select nominees. Key journals also were searched to locate other employers with innovative benefits plans.

The literature review and Advisory Panel discussion revealed the problems inherent in

developing a specific definition of “generous” or “comprehensive” benefits. No consensus on the issue exists. Reliance solely on a certain threshold of comprehensiveness would prove limiting. Thus, “comprehensive benefits” were defined more broadly to include such elements as EAPs and access to and flexibility of behavioral health services. All selected employers

- provide benefits that extend beyond traditional benefit limits, such as 30 inpatient days and 20 outpatient visits per year;
- place high priority on behavioral health;
- provide a range of innovative and flexible benefits (e.g., multiple levels of care beyond inpatient and outpatient treatment) and integrate behavioral health benefits with the corporate culture or other company elements such as an EAP;
- encourage employees to use needed behavioral health care;
- represent a geographically diverse group; and
- operate in a variety of industry sectors.

Companies that met these characteristics were contacted to assess their level of interest in participating. When a set of companies had been identified as potential participants, the recruiting process involved several challenges posed by the employers:

- concern about confidentiality of employee and employer health care and cost information;
- fear of being stigmatized by investors, clients, competitors, and potential employees as a company with a high prevalence of behavioral health disorders in its employee population;
- questions about resources required to devote to participation; and

- concern that national publicity would hamper the ability to reduce behavioral health expenditures in the future.

The group of six employers is primarily the product of self-selection. These employers shared several common characteristics, such as

- national reputation for providing comprehensive and innovative health and non-health-related benefits;
- national lines of business;
- extensive scope of operations, with Fortune 500 rankings ranging from 26 to 160;
- large workforce, ranging from 3,500 to more than 100,000 employees; and
- with the exception of Company X,³ self-insured employer status.

After study participants were selected, interviews with employer representatives were conducted and information was synthesized into individual case studies. Although the project originally examined behavioral health benefits, for the most part employers focused on the unique aspects of their mental health benefits. With few exceptions,⁴ the employers have devoted more resources to developing innovative programs for mental health than for substance abuse. To capture

³ This company has withdrawn its name from the study to avoid publicity during pending union negotiations. It participated fully throughout the process, provided researchers with all necessary information, and reviewed the case study. Other than the company name, no information has been altered. Some information concerning the company history and profile has been generalized to maintain confidentiality.

⁴ For example, Fannie Mae’s HMOs offer more generous coverage for substance abuse than for mental health. Its Aetna HMO plan provides up to 30 inpatient and 20 outpatient visits for mental health but places limits of 60 days for both inpatient and outpatient substance abuse care. The company’s Kaiser Permanente HMO also provides less restrictive substance abuse benefits.

these innovative, unique elements, this report concentrates on mental health benefits.

Participating employers use a variety of approaches—including HMOs, PPOs, and indemnity plans—to manage and deliver health benefits. The majority of participants contract with third-party administrators to manage benefits and provider networks. These contracted insurers, MCOs, and benefits administrators will be referred to as “insurers” or “vendors” throughout this report. The term “managed care organizations” refers to the two HMOs and one MBHO studied.

Criteria Involved in MCO Selection

The process of selecting MCOs differed substantially from employer selection.

First was a decision to focus the study on a staff model HMO and on a more open provider network such as a PPO. This strategy raised several issues, however, since most HMOs and PPOs offer a basic menu

of services and do not provide innovative behavioral health care.

The few exceptions were predominantly staff model HMOs. Although a staff model HMO was originally intended to be part of the strategy, very few employees receive care through such an HMO. Thus, to examine a more typical arrangement, two MCOs that had experience integrating a staff and network model were included in the study. Further, many MCOs use behavioral health carve-outs to manage mental health and substance abuse treatment. This study, therefore, examines one MCO specializing in behavioral health care.

After the types of MCOs to select were identified, three participants were chosen, based on

- a favorable National Committee for Quality Assurance (NCQA) ratings;
- nationally recognized behavioral health programs; and
- geographical diversity.

IV. Key Findings from Employers

Characteristics of Study Participants

While most are self-insured and therefore exempt from Federal and State mandates, all employers in this study nonetheless provide comprehensive mental health benefits. They provide the coverage voluntarily and report that they do so primarily because they

- believe that the mental health of employees is crucial to company success;
- recognize that mental health problems are common in the workforce and that early intervention and continuing treatment can address such problems effectively;
- have a “common sense” rationale that investing in the mental health needs of their employees will produce long-term savings by decreasing health care costs, increasing productivity, and reducing absenteeism; and
- understand that overall health care costs may rise when mental health benefits are restricted.

Study participants offer comprehensive mental health benefits as part of a larger corporate culture emphasizing the value of investing in employee overall wellness. This approach can be seen in the wide variety of nontraditional, non-health-related fringe benefits, such as financial incentives and work/life programs. The intent of such programs is to reduce unnecessary life stressors and to increase employee happiness and productivity. For example:

- Fannie Mae offers employee housing assistance, financial support for adoption, emergency child care services, and an elder care program providing case management and other services to parents and relatives of employees.
- Motorola has an extensive network of work/life programs designed to help employees balance the responsibilities of home and office. The company subsidizes in-home care for mildly ill children, on-site and near-site child care development centers, case management during pregnancy, free use of pagers for expectant parents, and on-site stress reduction massage therapy.

Corporate leadership can play a significant role in a decision to improve mental health benefits. In many cases, management’s determination to provide comprehensive care predates any expressed need for quantitative data to support decisions to alter benefits:

- First Chicago (a predecessor of Bank One) focused much of its benefit management approach on mental health as a result of the mental health background of one of its health benefits administrators.
- At Delta, the medical director’s interest in the association between depression and workplace productivity raised awareness of these issues throughout the company.

Mental Health Benefits: Design, Services, and Employee Cost-Sharing Requirements

Participating employers recognize that providing generous mental health benefits requires more than high-level services and low employee cost-sharing requirements. In addition to the specific benefits, these employers provide numerous mechanisms through which employees can access mental health care. All six employers encourage access to care through programs that fall outside of traditional services, such as:

- wellness programs;
- disease management programs;
- on-site psychiatric care;
- rapid-response teams for crisis intervention;
- employee incentives for participating in preventive health care programs;
- supervisor education and training to help detect mental health problems; and
- opportunities for employees to help shape provider networks.

Recognizing that cost-sharing can constitute a barrier to accessing treatments, many employers have developed cost-sharing structures that encourage employees to access mental health care, such as by eliminating employee out-of-pocket expenses for initial visits or for EAP use.

All six employers invest significant resources in EAPs—programs that provide a wide range of services under the broad goal of increasing access to care. The range of these services varies by company. Some employers have on-site EAPs, providing free counseling in the workplace, while others believe employees are more likely to use an EAP when it is located off-site.

One company, Eli Lilly, offers mental health benefits at levels that exceed parity with physical health coverage. The company's Uniform Mental Health Benefit offers lower cost-sharing requirements for mental health than physical health benefits.

While no employers offer absolute parity between physical and mental health benefits, most do use alternative mechanisms to ensure comprehensive mental health care. In general, employers encourage initial access to mental health care through free or reduced-cost initial visits, but place more limits on extended use of outpatient psychiatric benefits than on physical health care services of similar duration.

Most companies exceed parity in some areas and fail to reach it in others. Some plans offer complex cost-sharing schedules that produce more generous mental health benefits at certain utilization levels and more generous physical health coverage at others. For example, a Bank One employee pays lower average out-of-pocket costs for mental health care than for physical health care if using fewer than 14 sessions a year; additional use produces average mental health copayments greater than the \$15 physical health copayment.

Several employers provide services along a continuum of care, offering benefits that extend beyond traditional inpatient and outpatient treatments. For example, Eli Lilly's Uniform Mental Health Benefit includes three graduated alternatives for outpatient care, ranging from nonintensive diagnostic and testing services to a partial inpatient program.

In making decisions about benefit design, several employers take into account the characteristics of their particular workforce (e.g., gender, age, type of profession). As a result of its largely female population, Bank One has

invested heavily in depression screening and management programs in response to women's higher incidence of depression.

All employers recognize the direct link between the well-being of an employee's family members and the mental health status of that employee. Because of this knowledge, some employers provide free EAP services to all members of an employee's household.

Many benefit managers characterize their EAP as a "gateway" to services, as opposed to a traditional "gatekeeper" limiting access to services. EAPs more often serve as a direct link to the benefit plan's network of mental health providers.

Benefit Management Approaches

All six employers manage their mental health benefits in different ways; no single formula defines the management approach necessary to provide comprehensive or innovative benefits. Companies make many benefit management decisions, including the following:

- *Integrate or carve out services:* In general, the employers studied do not appear to show a strong preference when distinguishing between health plans that integrate mental health services within their physical health systems and plans that subcontract with MBHOs. Companies can provide comprehensive benefits and meet other goals, including administrative simplicity, quality of care, and access to providers, through either method.
- *Internal or external management:* Employers tend to maintain responsibility for some or all of their mental health benefits more often than for physical health, enabling them to respond more directly to employee needs.
 - Eli Lilly directly manages a uniform benefit, providing coverage for all

company employees who need access to mental health services.

- Motorola partners with a vendor to operate a customized provider network that includes mental health specialists.
- Delta, Bank One, and Motorola all operate internal EAPs to promote interaction between the EAP and the benefits plan and to enable EAP personnel to understand the corporate culture.
- *Single or multiple contracts:* Using a single vendor enables employers to centralize benefits and simplify administration, provide consistent benefits to all employees, and leverage their full purchasing power.
- *National or regional design:* As a result of the desire to operate fewer contracts, employers face pressures to manage their mental health benefits on a national basis. Some employers resist the trend toward nationalized benefits by retaining regional contracts. A regional approach (e.g., the approach used by Company X) provides closer interaction and the ability to forge partnerships with vendors, enhances knowledge of and ability to respond specifically to a particular region's employee population, and ensures vendor familiarity with the quality of local providers. All six companies exhibit this desire to limit the number of contracts; many companies consolidate benefits nationally.

While employers use a wide variety of approaches, all take an active role in directly managing both plans and vendors. Companies evaluate their plan options regularly and work to improve inadequacies.

Employers recognize the need to communicate their benefits approach to insurers,

EAP vendors, and providers. In developing its customized provider network, Motorola found that ensuring that providers understand the company's approach to be the greatest challenge.

Several companies make a significant investment in relationships with vendors. For example, Company X has partnered with the same vendor since 1997, facilitating creation of an integrated co-case management program for members who may benefit from treating potential comorbid physical and mental health conditions.

Employee Satisfaction/ Performance Data

The majority of employers do not use performance data to assess the relationship between access to mental health services and employee productivity and health care costs. Therefore, with the exception of Bank One, employer decisions to provide comprehensive mental health benefits have been independent of such data.

Employers require vendors to adhere to performance standards that are most often developed by external organizations, such as the NCQA, purchasing groups, and business groups on health. Instead of creating customized measures, employers use these standardized data to monitor vendors and create HMO report cards. Unfortunately, such industry standard performance measures often do not capture mental-health-specific information.

Employee feedback plays a significant role in shaping the benefit design and influencing policies at all of the companies:

- In addition to assessing employee satisfaction and improving areas of poor performance, most companies are willing to change policies based on employee com-

plaints. Thus, when a number of employees insisted that a particular drug should be included on its managed care plan's formulary, Delta required the vendor to add the medication.

- Several companies rely heavily on employee input, through focus groups and direct interviews, in creating benefits plans. Employee dissatisfaction with managed care plans, for example, served as a catalyst for Motorola's decision to add an option for a customized preferred provider network.

Specific Examples of Best Practices

Comprehensive and innovative mental health benefits take a variety of forms; no one approach provides a complete formula necessary for providing such benefits. Instead, the six employers studied use a range of "best practices" in mental health benefit design, management, and data monitoring.

Bank One: Tracking the Connection Between Claims Data and Treatment Interventions

Bank One is one of the few employers in the Nation that tracks the effects of mental health spending. Through an advanced computer information system, the company monitors disability and absenteeism. It has found a direct link between increased mental health spending and decreased employee health problems.

Delta Air Lines: Tailoring Benefits to Meet Specific Needs of Employee Population

As a member of the airline industry, Delta faces a variety of special challenges. Federal regulations ground pilots taking psychoactive medications, including antidepressants; this often makes pilots fearful of seeking mental health treatment. Delta recognizes the special

needs of this unique population and has attempted to structure its benefits plan accordingly.

Eli Lilly: Managing Mental Health Benefits Internally to Ensure Access to Care

To improve employee mental health care, Eli Lilly terminated its contract with a behavioral health carve-out plan and began to provide all mental health coverage through an internally managed indemnity plan. The Uniform Mental Health Benefit encourages utilization through high levels of coverage and no deductibles.

Fannie Mae: Fostering Mental Health Through Wellness Programs and On-Site Care

Fannie Mae offers a wide variety of physical and mental health work-site wellness programs designed to help employees balance work and home life. The company provides on-site psychiatric care, including a variety of consultative and administrative services such as case management for employees receiving treatment, advocacy on behalf of employees enrolled in managed care, and general advice about the company's benefits plan.

Motorola: Customizing a Provider Network Based on Employee Preferences

To ensure that employees requiring mental health treatment receive the highest possible quality of care, Motorola has customized a network of mental health specialists based on employee preference and past claims data.

Company X: Using Competitive Bidding Under a Regional System

Company X's expertise in competing for Federal contracts through bidding has helped it select and manage its own subcontractors. Company X modified its Federal bidding

practices to develop a competitive bidding system for vendors, enabling the company to select the best mental health care vendor in each region.

Challenges Remaining

The pervasiveness of corporate mergers and acquisitions presents numerous challenges to administering and providing employees with mental health benefits, including the following:

- consolidating benefits so that employees have access to uniform benefits;
- becoming familiar with the needs of new employee populations;
- maintaining leadership despite the loss and turnover of executives;
- integrating historical health and claims data from component companies; and
- decreasing the number of health care vendors.

Managing multiple contracts, as well as ensuring vendors share the company's approach to mental health care, remains a key challenge. For example, Bank One, which holds contracts with more than 50 HMOs, is currently consolidating its HMO choices. Employers also face challenges in communicating the corporate philosophy that underlies the mental health benefits, as insurers frequently focus on controlling costs. In addition to managing multiple vendors, employers must integrate data from a variety of vendor database systems that may not be compatible with the company's system.

Mental health education remains critical, since many employees still fear the stigma of mental illness and its potential adverse effects on employment. Such difficulties are particularly acute when a diagnosed mental health condition can significantly affect an employee's job status, such as

the Federal Aviation Administration requirement grounding any airline pilot taking psychoactive medications.

Increasing regulatory and financial pressures on the managed care industry also are taking a toll on employers. Facing cost pressures from purchasers, MCOs may reduce service levels and increase health insurance premiums to remain financially viable. Furthermore, employers fear that mandated parity legislation could require a

standardized approach that will limit their development of innovative programs customized to employee needs.

The experiences described by participants in these case studies (see Appendix C) can help guide other companies that are preparing to redesign their benefits to meet parity regulations. The cases also illustrate examples of best practices for corporations engaged in efforts to improve employee access to mental health care.

V. Key Managed Care Organization (HMO and MBHO) Findings

Characteristics of Study Participants

Leadership plays a significant role in defining the MCOs' approaches to providing care. (Details of individual MCO case studies are in Appendix D.) For example, Harvard Pilgrim's founding members included several psychiatrists who understood the necessity of integrating physical and mental health care. American Psych Systems' (APS's) management facilitated the organization's development of policies and innovative programs that demonstrate its dedication to providing high-quality mental health care.

While the two HMOs began in the 1970s as staff models, both now operate as mixed models with large provider networks. Both provide a continuum of mental health care throughout all of their plan options; offering comprehensive coverage does not require a specific type of delivery model.

To remain competitive, APS has developed its niche by specializing in small to mid-size employer and HMO clients. This MBHO offers its private and public sector customers a range of products including EAPs, managed behavioral health care programs, and administrative services. Behavioral health care programs are the company's fastest growing business segment.

Mental Health Benefits: Design, Services, and Employee Cost-Sharing Requirements

The HMOs and MBHO place a high priority on integrating physical and mental health care services, as well as requiring open communication and coordination of care between mental health specialists and primary care physicians. For example, APS requires mental health providers to contact a patient's primary care physician when medical conditions present may be complicated by medication or other psychiatric treatment.

The MBHO establishes reasonable and affordable employee cost-sharing requirements because it recognizes that high out-of-pocket expenditures often discourage individuals from accessing mental health benefits. The company also encourages employers to provide services under the EAP at no cost to employees because an EAP offers certain insured populations (e.g., blue collar workers) greater access to services.

All three MCOs offer a wide range of services along the mental health continuum of care. They acknowledge that limiting services to inpatient and outpatient care will not produce positive patient outcomes in the long term.

Benefit Management Approaches

The MCOs report that, in contrast to the six employer study participants, the majority of employers do not manage benefits actively. Instead, many prefer to purchase a prebundled set of services. When they do customize plan design, a task more easily accomplished when the purchaser is self-insured and at risk for the benefit, employers rarely place increased restrictions on services, but instead require additional options or levels of coverage.

HMOs have felt the effects of recent trends toward consolidated and nationalized benefits. All three MCOs use regional strategies to provide care. As more employers purchase benefits through national plans, smaller regional vendors will receive a decreasing market share of private sector business. To remain competitive, these vendors may be required to alter their approach to mental health care.

Employers and HMOs are primarily concerned with a behavioral health care organization's ability to maintain a high-quality provider network and to ensure that patient costs will not increase (particularly because mental health is such a small percentage of an HMO's overall budget). APS, however, believes the most effective method for achieving these goals is through use of innovative payment approaches and minimal direct management of providers. As a result, the MBHO can shift resources from quality control and oversight to focus on monitoring treatment retrospectively for quality and satisfaction.

Employee Satisfaction/ Performance Data

NCQA HEDIS measures comprise most of the performance data reported by HealthPart-

ners and Harvard Pilgrim. Both use member surveys to measure satisfaction, quality of care, cost of care, and access to services. In addition, they monitor behavioral-health-specific measures including hospital re-admission for mental health patients, anti-depressant medication management, and mental health, chemical dependency, and prescription drug use and cost.

APS tracks a wide variety of claims, access, treatment, and outcomes measures through an automated information system, enabling the company to conduct historical comparisons, trend analysis, and ongoing quality improvement.

The MBHO also monitors data included in industry standards, such as the HEDIS measures and the American Managed Behavioral Healthcare Association's Performance Measures for Managed Behavioral Healthcare Programs (PERMS). These standardized sets of performance criteria can provide useful information. For example, when it analyzed the PERMS data for 1998, APS identified a need to improve the rate of ambulatory followup care for patients hospitalized with a substance abuse diagnosis.

Specific Examples of Best Practices

Harvard Pilgrim Health Care:

Ensuring Care Across Plan Boundaries

The evolution of PPOs has made providers dependent on payments from a variety of insurers. This dynamic has reduced MCOs' ability to require providers to implement particular programs for each MCO's specific covered populations. Harvard Pilgrim has responded to this problem by instituting a depression screening program in which it pays providers for any patient screenings,

including those for patients not enrolled in Harvard Pilgrim plans.

HealthPartners: Uniting Primary Care Physicians and Mental Health Consultants

Recognizing that primary care physicians provide the majority of mental health care, HealthPartners has developed a program in which mental health specialists consult with these physicians. As a result, the primary care physicians have a greater mental health support network when diagnosing and treating individuals with a range of psychiatric problems.

American Psych Systems: Developing Strong Relationships with Network Providers

APS has placed a high priority on fostering long-term relationships with its provider networks. After providers pass the company's stringent selection criteria, APS allows them to make the majority of treatment decisions with minimal intervention. The company has also developed a computerized system to expedite any necessary preauthorization and claims payments, enabling providers to focus on patient care.

Challenges Remaining

The burgeoning popularity of larger provider network options has led to a transition away from staff model HMOs. Extensive networks disperse a provider's population among many different MCOs, limiting the influence those vendors have over the provider. As a result, MCOs have more difficulty developing innovative programs for these provider networks than under staff models.

Increasing pressures from employers to reduce health care expenditures may force HMOs to decrease service levels and to eliminate the innovative services currently provided.

As employers transition from regional to national MCOs, smaller vendors are concerned about their ability to accommodate employer needs under a regional design and must convince employers that they can provide higher quality benefits through a regional approach.

MBHOs often act as subcontractors, providing behavioral health services as part of health benefits offered through an HMO. In such situations, the MBHO does not work directly with employers, limiting its ability to collaborate with an employer to understand and customize benefits to a company's specialized needs.

VI. Appendix A: Advisory Panel Roster

Committee Members

Larry Boress
Vice President
Midwest Business Group on Health

Jane Galvin
Managed Care Policy Director
Health Insurance Association of America

Dorothy Graham
Director of Human Resources
Puget Sound Energy

Robert Hess
William M. Mercer

David Hirschland
Assistant Director
Department of Social Security
United Auto Workers

Ben Lytle
Chief Executive Officer
Anthem, Inc.

Donald W. Parsons, M.D.
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The Permanente Foundation

Center for Mental Health Services

Jeffrey Buck, Ph.D.
Director, Office of Managed Care
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

Catherine Acuff, Ph.D.
Contractor
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

VII. Appendix B: List of Study Participants

The Lewin Group interviewed the following individuals for this study.

American Psych Systems

Richard Beland
Vice President, Sales and Marketing

Gary Bucello
Vice President, Clinical Operations

David Faber
Medical Director

David Hunsaker
President, Public Sector Programs

Rich Lenz
Director, Employee Assistance Programs

Helene Roybal
Executive Vice President, Operations

Laurie Van Der Heide
Vice President, Quality Improvement

Bank One

Daniel J. Conti
Vice President,
Employee Assistance Program Director

Delta Air Lines, Inc.

Thomas Faulkner
Regional Medical Director,
Air Crew Health Services

Eli Lilly and Company

Gregory Larkin
Director of Corporate Health Services

Sheila Monaghan
Corporate Director
Global Employee Consultation Services

Fannie Mae

Nancy Collins
Senior Human Resource Specialist

Helen Irving
Manager, Health and Work Life Center

Eliot Sorel
On-site Psychiatrist

Harvard Pilgrim Health Care

Cassandra Eckhof
Project Manager
Mental Health Executive Committee

Judy Feldman
Chief, Central Mental Health
Clinical Programs
Harvard Vanguard

Marianne Gibbons
Center for Employer Health Programs
Harvard Pilgrim Health Care

James Harburger
Director of Mental Health Services
Harvard Vanguard

Thomas Hawkins
Center for Employer Health Programs
Harvard Pilgrim Health Care

Steve Stelovich
Medical Director of Mental Health
Harvard Pilgrim Health Care

HealthPartners

Macaran Baird
Associate Medical Director for Primary Care

Mary Burland
Manager, Case Management

Ann Gjelten
Vice President, Sales

Karen Lloyd
Director, Behavioral Health Policy

Nico Pronk
Senior Director, Center for
Health Promotion

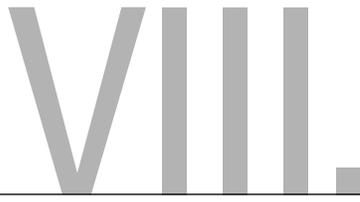
Theodore Wise
Senior Vice President, Consumer Choice

Motorola

Randall Johnson
Director of North America Benefits

Company X

Director, Corporate Benefits
Employee Assistance Program Director



Appendix C: Employer Case Studies

A. Bank One

Company History / Profile

In 1998, Bank One became the fourth largest U.S. bank holding company as Banc One Corporation merged with First Chicago NBD (FCNBD) Corporation⁵ to form Bank One. The merger completed Bank One's transition from a decentralized company with strong regional management to a nationally organized corporation. Bank One now operates five national lines of business: Commercial Banking, Credit Card, Retail Banking, Finance One, and Investment Management. Its credit card business, operating the *First U.S.A.* and *First Card* brand names, is the world's largest issuer of VISA credit cards. The corporation's investment management sector ranks as one of the Nation's 25 largest mutual fund managers.

The merger has posed significant challenges because of Bank One's size and international presence. The company's 90,000 employees operate in more than 2,000 banking centers in 34 States and 11 countries around the world. Bank One's decision to restructure its operations along national lines compounded the general turnover and transition in the workplace. One of the first corporate priorities identified after the merger and

restructuring involved consolidating the company's benefits. After comparing and evaluating the legacy benefit packages and management strategies, Bank One identified each company's best practices and developed a single approach for corporate implementation. As a result, Bank One adopted FCNBD's method(s) of managing employee health care and costs, an area in which FCNBD had earned a national reputation.⁶

Factors Influencing Company's Decision to Provide Comprehensive Benefits

Bank One recognizes that providing comprehensive benefits is mutually beneficial for employer and employee because it reduces overall corporate costs and ensures a healthy workforce. The company has developed a comprehensive data monitoring system to evaluate benefit management decisions. In the 1980s, the company realized that its benefit structure discouraged employees from seeking outpatient care. Popular opinion held that increasing access to outpatient services would result in overutilization and increased costs. When FCNBD increased outpatient coverage, however, it experienced decreased mental health costs per employee. Between 1985 and 1997, mental health costs fell from 15 percent to 6 percent of total health costs.

⁵ First Chicago NBD Corporation represents a December 1995 merger between First Chicago Corporation and NBD

⁶ This case study will present some of the history of FCNBD's initiatives because Bank One has inherited many of the key resources the company uses to manage healthcare benefits.

The company identified other indirect cost savings not included in cost-benefit analyses. For example, Bank One's benefit plan has gained national recognition and has been a formal component of the firm's recruiting and retention strategies.

Mental Health Benefits

Description of Benefit Options

Bank One offers employees several coverage options. Employees can choose among a variety of HMOs,⁷ a POS plan, a PPO plan, and a traditional indemnity plan for physical

health care. All non-HMO enrollees receive a uniform set of mental health benefits.

Tables 2–4 provide specific information on Bank One's mental and physical health plans.

Mental health benefits must be accessed through the EAP. Although the EAP serves as the gateway to the mental health benefit, the EAP network includes all contracted mental health providers. Integration of the EAP and the mental health network yields a benefit structure offering three free outpatient visits (traditional EAP visits) followed by incremental increases in cost-sharing requirements as the number of visits increases. These networks also facilitate continuity of care, since patients can continue treatment with the same provider. In 1993, FCNBD decided to

⁷ The HMO Options are too numerous and varied to list in tables.

Table 2: Summary of Benefit Structure: Uniform Mental Health Coverage for PPO, POS, and Indemnity Plan Enrollees				
<i>Service</i>	<i>Copayments</i>	<i>Coinsurance</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	No deductible in-network; \$400 deductible out-of-network			
Out-of-pocket maximum	\$1,000 per individual in-network; \$2,000 per individual out-of-network			
Inpatient mental health	No copayment	90% in-network; 70% out-of-network	No limit	No limit in-network; 30 days per year/ 90 days per lifetime out-of-network
Outpatient mental health	No copayment, sessions 0–3; \$15, sessions 4–10; \$25 sessions 10+	100% in-network; 70% out-of-network	No limit	No limit in-network; 20 visits per year/ 90 visits per lifetime out-of-network
Nonhospital residential	No copayment	100% in-network; 70% out-of-network	No limit	No limit in-network; 90 days per lifetime out-of-network
Intensive nonresidential	No copayment	100% in-network; 70% out-of-network	No limit	No limit in-network; 90 days per lifetime out-of-network
Crisis-related	No copayment	100% in-network; 70% out-of-network	No limit	No limit in-network; 20 visits per year/ 90 visits per lifetime out-of-network
Medication management	\$5 in-network; no copayment out-of-network	100% in-network; 70% out-of-network	No limit	No limit in-network; 90 days per lifetime out-of-network

<i>Service</i>	<i>Copayments</i>	<i>Coinsurance</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	No deductible in-network; \$400 deductible out-of-network for both physical and mental health care			
Out-of-pocket maximum	\$1,000 per individual in-network; \$2,000 per individual out-of-network for both physical and mental health care			
Inpatient physical health	No copayment	90% in-network; 70% out-of-network	No limit	No limit
Outpatient physical health	\$15 in-network	100% in-network; 70% out-of-network	No limit	No limit

<i>Service</i>	<i>Copayments</i>	<i>Coinsurance</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	No deductible			
Out-of-pocket maximum	\$1,000 per individual			
Inpatient physical health	No copayment	90%	No limit	No limit
Outpatient physical health	\$15	100%	No limit	No limit

contract with a pharmacy benefit manager; the new prescription drug benefit covers 85 percent of pharmaceutical costs without a deductible and applies to medications for both physical and mental illnesses.

Employee Assistance Program

Established in 1979 to address chemical dependence in the workplace, FCNBD's EAP has experienced significant change in the past two decades. Currently, the first three mental health outpatient visits count as EAP visits. To ensure broad EAP utilization, employee materials advertise the benefit. The company also requires all managers and supervisors to take a class called "Managing the Troubled Employee." Employees frequently talk with managers about health concerns and often

receive referrals from supervisors directly into the EAP.

Traditionally, 5 percent of Bank One employees have used the EAP annually. The EAP most frequently deals with stress, emotional disorders, marital and family difficulties, alcohol and drug dependencies, and problems coping with aging parents. In addition, program professionals work as case managers for patients with short-term disabilities.

Benefit Management

Bank One's benefits department manages the HMO, PPO, and POS plans and administers the self-insured indemnity plan, wellness programs, and on-site care. The company's benefit managers rely heavily on data gathered through Bank One's integrated health data-

base. Bank One uses Integrated Health Data Management System (IHDMS) data to guide decisions about contract renewal; if an HMO performs poorly, Bank One may terminate the contract. In addition, the company monitors indicators (e.g., recidivism rates) to determine which providers and hospitals are producing the best patient outcomes.

The company has created an internal diversity-monitoring group to ensure that Bank One benefits are responsive to its diverse employee population. It uses this group to customize the mental health benefits to Bank One's specific employee population. For example, if the company found that women were seeking EAP services more than men, the program would be directed to develop a plan to address the specific needs of women.

Bank One's medical department oversees the EAP and on-site medical centers. Bank One has adopted FCNBD's strategy of using the medical centers to play an integral role in designing the wellness, mental health, and other key components of the plans. The medical centers also help evaluate ongoing quality of care.

As it experienced increased employee enrollment in managed care in the 1990s, FCNBD began to forge partnerships with its vendors to provide higher quality patient care. The database enables Bank One to approach its HMOs and PPO with evidence of effective treatment protocols. By demonstrating that a specific treatment protocol is cost-effective, the company can convince a vendor to offer such care.

Key Program Components/Best Practices

- **Integrated Health Data Management System enables Bank One to analyze**

clinical outcomes, disease management, and short-term disability.

In 1986, Bank One began to search for ways to manage health care and disability costs more effectively and to evaluate the impact of benefits and wellness programs on overall health costs. FCNBD's medical department created the IHDMS computer system to track direct and indirect costs related to health and disability (Burton & Conti, 1998). FCNBD was one of the first companies in the Nation to examine systematically the indirect costs related to decreased productivity, absenteeism, and short-term disability.

Medical department staff, including occupational health nurses, EAP psychologists, and counselors, enter data directly into the database. A variety of security measures, including multiple levels of encryption, ensure confidentiality of the records. Currently, the system integrates demographic and personnel data for active employees, dependents, and retirees; data on work-site wellness programs; safety records and accident reports; medical claims; workers' compensation and short- and long-term disability claims; EAP records; clinical factors; and productivity data (Burton & Conti, 1998).

The system can provide information, such as clinical outcomes, disease management, and short-term disability, useful in designing and monitoring the mental health benefit.

- **Clinical outcomes:** Using IHDMS information, Bank One can monitor patient utilization patterns to determine the efficacy of a particular treatment for a particular illness. Comparing outcomes of different treatment paths for individuals with the same diagnosis can reveal differences in patient outcomes and cost-effectiveness. The company then can

encourage providers to use the more effective clinical strategies. Bank One also can examine information such as hospital readmissions to determine the quality of care being provided.

- **Disease management:** FCNBD analyzed 1993–1995 direct and indirect costs associated with five common chronic diseases identified in its workforce: depression, diabetes, asthma, hypertension, and ulcers (Burton & Conti, 1998). Of these diseases, depression resulted in the most employee absences per event, resulting in the greatest direct and indirect costs.² This information served as a catalyst in the initiation of a depression disease management program.

According to IHDMS data, implementation of a disease management program decreased medical costs for depression from \$71 per covered employee in 1993 to \$61 per covered employee in 1995 by shifting care to outpatient settings. While outpatient costs increased and pharmacy benefit costs quadrupled, inpatient costs declined sufficiently to result in an overall cost savings. The benefits department is now working to identify the characteristics and specific benefit needs of the larger and more diverse employee population.

- **Short-term disability:** Bank One's short-term disability management program unites intense case management with early intervention. Bank One solicits information concerning disability absences from managers and employees. An employee's physician must submit a disability form, or the company may suspend salary and ben-

efit payments. Once a physician reports the disability, Bank One assigns a case manager to follow treatment and to support the employee's return to work.

Bank One's EAP provides case management for disabilities involving psychiatric conditions; the company recognizes that many instances of disability are caused by either a mental health problem or a comorbid mental health condition. The care management program has reduced average work days missed from 46 to 40 days, a figure in line with the company's goals. The company found that before case management was implemented, 18 percent of employees who accessed the EAP did so more than once in a 12-month period, compared with 16 percent afterward.

- **Medical centers provide on-site risk assessment, education, and care.**

Bank One operates on-site medical centers in several locations throughout the country. These centers provide a variety of services including treatment of ill or injured employees, wellness programs, short-term disability management, and periodic health evaluations. Under the aegis of these medical centers, FCNBD established a comprehensive Wellness Program in 1984. This program, continued by Bank One, provides a variety of programs—including health education, health risk assessment, an on-site mammography program, and prenatal classes and care—designed to improve the health status of employees and their families in order to reduce unnecessary treatment and disability costs (Burton, 1998).

Employee Satisfaction / Performance Data

The benefits department uses IHDMS data to evaluate contract providers and to provide detailed cost and productivity data. The company monitors short-term disability occurrence rates, average length of each disability event, recidivism rates, and other information to provide a comprehensive picture of the HMO's mental health program.

Bank One also evaluates employee satisfaction and service utilization. Annual report cards detailing satisfaction with and quality of each HMO are given to each employee during benefit enrollment and to each MCO. In 1993, when the company began using a pharmacy benefit manager, FCNBD also began tracking pharmacy data.

Lessons Learned and Challenges Remaining

Bank One has learned key lessons from its experience providing comprehensive mental health benefits; it also has identified several specific challenges.

Lessons Learned

- Increased emphasis on mental health benefits (combining low cost-sharing requirements, expanded services, no separate benefit caps, and a sophisticated EAP) can result in lower total health expenditures.
- Collecting and accurately managing health care data can help improve patient outcomes. A comprehensive data management system can help determine the impact of benefit changes. However, if analysis is limited to tracking and examining direct costs, the total costs of a disease can be seriously underestimated.
- Company benefit plans should reflect the specific characteristics of their employee workforce. Thus, since its workforce includes significant numbers of relatively

young, female workers (a population with a higher rate of depression than men), Bank One developed specific programs to target depression.

Challenges Remaining

- The Bank One merger requires consolidation of mental health benefits across multiple new employee populations and geographic regions. Information from three times as many employees now must be integrated into its IHDMS database. Bank One currently contracts with over 50 HMOs, dividing employee mental health services across many different providers. The company is now integrating the EAP and mental health benefits for all non-HMO enrollees into a single plan. Furthermore, it is consolidating its HMO contracts.
- Bank One is working to improve its relationship with vendors. While the goal is a partnership between the two entities, Bank One is further along this path with some HMOs than with others.
- Bank One must develop methods to evaluate covered employee and family functional status and quality of life.

B. Delta Air Lines

Company History / Profile

Delta Air Lines, Inc., operates scheduled air transportation for passengers, freight, and mail over an extensive worldwide route. The third largest U.S. airline in operating revenues and passenger miles flown, Delta has more passengers and more aircraft departures than any of its competitors. In addition to pilots and flight attendants, Delta's 70,000 employees include ticket agents, gate agents, aircraft

mechanics, engineers, business executives, and a wide range of other staff.

Factors Influencing Company's Decision to Provide Comprehensive Benefits

The early 1990s was a difficult financial period for the entire airline industry. During the first half of the decade, Delta undertook cost-cutting measures to offset poor financial performance, including severe reductions in force (RIF's) that, according to the company's 1998 annual report, "threatened Delta's core values of high employee morale" (Mullin, 1998, p. 2). Declining morale ran counter to the ideal of the "Delta family," a philosophy centered on respect and teamwork among all Delta employees. To rekindle this attitude, the airline focused more intensively on its employees, implementing changes such as increasing employee salaries in January 1999. The company emphasizes that its employees provide the "centerpiece of success" and that they deserve to be compensated at the top of the industry (Mullin, 1998, p. 3).

The airline's financial hardships also affected its mental health benefits. During the first half of the decade, many employees who had never doubted their job security began to worry that they might be "downsized." An increased number of employees experienced depression and anxiety. As a result, Delta improved mental health coverage and instituted programs, such as the EAP, to provide additional employee support. Delta's employee-focused culture improved morale dramatically in fiscal 1998. An independent survey revealed that overall employee satisfaction jumped 20 percent from 1996 to 1998.

Mental Health Benefits

Description of Benefit Options

Only recently has Delta made the transition from fee-for-service health coverage to managed care. In 1995, in the wake of growing fee-for-service health care costs, Delta contracted with CIGNA HealthCare and several smaller insurance companies to provide managed care for employees. Delta remains self-insured, relying on these contractors to manage the health benefit plans.

Approximately three-quarters (53,000) of Delta's 70,000 employees are insured through the airline. Of these enrollees, 90 percent participate in plans run by CIGNA. This case study focuses on these nearly 48,000 Delta employees enrolled in the CIGNA plan who are covered through an HMO with a POS provision allowing for out-of-network care. The remaining 10 percent select coverage from either smaller fee-for-service plans or regional managed care insurers, such as Kaiser Permanente on the West Coast and United Healthcare in the eastern half of the country. Delta offers coverage to all full- and part-time employees, spouses, and dependents; the company is currently considering coverage for domestic partners. Employees can petition for coverage of a sibling or parent in their care (see Table 5).

Table 5: Summary of Benefit Structure: CIGNA HMO Plan				
Service	Copayments	Coinsurance	Annual/Lifetime Dollar Limits	Annual/Lifetime Day/Visit Limits
Deductible	No deductible for either physical or mental health care			
Out-of-pocket maximum	No maximum for either physical or mental health care			
Physical Health				
Inpatient	No copayment	100%	\$2 million per lifetime	No limits
Outpatient	\$10 in-network; out-of-network varies*	100% in-network; out-of-network varies*	No limits	No limits
Mental Health				
Inpatient	No copayment	100%	\$200,000 per lifetime	No limits
Outpatient	\$10 in-network; out-of-network varies*	100% in-network; out-of-network varies*	No limits	No limits
Nonhospital residential	Not covered	Not covered	Not covered	Not covered
Intensive nonresidential	Not covered	Not covered	Not covered	Not covered
Crisis-related	Not covered	Not covered	Not covered	Not covered

* Out-of-network cost-sharing arrangements include both lower coinsurance (from 30 to 70 percent coinsurance depending on the type of care) and higher copayments (as high as \$20).

Delta contracts through CIGNA with a third party, MCC Behavioral Care, Inc., to provide mental health benefits. CIGNA thus manages Delta’s physical health benefits and serves as an intermediary between Delta and MCC for mental health care. Mental health care is about 10 percent of Delta’s total health care budget.

In the past few years, at the behest of Delta, MCC has reduced its limitations on mental health coverage. The plan now considers psychiatrists and psychologists as primary care physicians. The result: unlimited outpatient access. Utilization restrictions apply only to physical and mental health specialist care. Employees do not need to contact the EAP or another gatekeeper to access the mental health benefit.

Delta covers employee premiums; coverage for a spouse costs an employee an additional

\$15 biweekly; coverage for a dependent child is available for \$10 biweekly.

Medications are covered with a \$10 copayment for both name-brand and generic drugs; no distinction is made between physical and mental health pharmaceuticals.

Employee Assistance Program

When Delta first entered the managed care market, it contracted with MCC for both the EAP and the mental health benefit. Delta soon grew dissatisfied with the external EAP arrangement and decided to manage its own EAP. Delta now contracts with MCC only for mental health coverage.

In the past few years, Delta’s internal EAP has grown from a staff of three in the Atlanta office to 12 licensed social workers working throughout Delta’s major geographic hubs. Currently, each counselor sees or speaks with

approximately 30 employees and family members every week.

The EAP counselors frequently help employees and family members with anxiety, depression, and substance abuse problems. While no limits are placed on EAP visits, in most cases, counselors need about four visits to determine whether EAP intervention is sufficient or outside specialist care is warranted. When a patient experiences no improvement, expresses indications of self-harm or harm to others, or otherwise requires additional treatment, the EAP counselors refer the individual to providers in the managed care networks.

The EAP has reduced significant sources of tension for supervisors by enabling them to refer employees to professional counselors. The EAP staff also can intervene with supervisors to improve employee performance and productivity.

Benefit Management

CIGNA manages the entire health benefits plan, including mental health benefits through MCC and the pharmaceutical benefits plan. CIGNA's national presence allows Delta to maintain administrative simplicity and uniform health benefits across the country. The airline found that CIGNA was one of the few MCOs able to offer such widespread coverage. Delta does contract with other vendors in regions where the vendors have a strong presence.

Although CIGNA manages the benefits, Delta plays an active role in ensuring quality of care. In 1994, it established a Health Services Department to oversee the benefits packages and the EAP. Employee complaints go directly to this department. CIGNA usually responds quickly to accommodate the airline. For example, if a significant number of employees believe that a drug should be

included on the formulary, Delta requests that CIGNA add the drug to the list; CIGNA usually complies.

Furthermore, two CIGNA employees have their offices in the Delta Health Services Department, enabling CIGNA to manage complaints directly from Delta's offices. CIGNA also has created a special toll-free phone number for Delta employees.

Key Program Components / Best Practices

Delta places great value on its employees' overall wellness; the airline believes this corporate culture contributes to the average employee retention of approximately 17 years. Key components of Delta's mental health benefit and EAP reflect this dedication.

- **Delta works to ensure employee satisfaction in managed care.**

When the company moved from fee-for-service to managed care, some employees no longer could see their providers of choice. The company eased the transition by expanding its network and by allowing employees to change providers at will.

The company frequently discusses employee insurance policy problems with CIGNA to effect change and to advocate on behalf of individual employees. Thus, Delta works to prevent exclusions from its pharmaceutical formulary and seeks the input of both physicians and employees in designing it. As a result, the insurance covers most prescription medications. For mental health, the formulary includes many types of antipsychotics and antidepressants.

- **Localized EAP improves ability to respond directly to specific employee problems.**

In addition to a confidential telephone hotline, Delta's EAP provides a range of

employee counseling services. Because the EAP counselors in each area are local Delta employees, they know the corporate culture, the types of jobs, and the characteristics of individuals employed in a certain area. The EAP staff thus can respond to problems on a personal basis and are familiar with challenges specific to Delta employees.

- **Benefit design addresses challenges specific to the company's employees.**

Because Delta faces industry- and population-specific challenges (such as mental health care for pilots), the airline has designed its mental health benefit to best address these issues. Federal Aviation Administration (FAA) guidelines restrict pilots from flying if they are taking certain prescription medicines, including antidepressants and antipsychotics. The FAA fears not only that the drugs may not work correctly, but also that such medications may make pilots drowsy or have other physiological or psychological effects. As a result, many pilots fear the FAA may ground them if they see a psychiatrist or call the EAP. Although the FAA allows pilots to seek counseling, such concerns create a severe obstacle to appropriate treatment. Moreover, pilots experience high rates of substance abuse and co-occurring depression. Delta's EAP is working to address this industry-wide problem by educating employees that EAP use is confidential and encouraging them to seek assistance.

Employee Satisfaction / Performance Data

Delta continues to monitor CIGNA's performance, conducting surveys of employee satisfaction with CIGNA and with the benefits plan in general. Although Delta has

focused primarily on employee satisfaction, the airline plans to analyze cost and utilization data in the near future. Delta also is assessing the effect of adequate mental health treatment on employee physical health since it believes that mental health care may both reduce physical health problems and increase productivity.

The new EAP is the focus of several evaluations, including both a feedback survey of employees who have used the service and an assessment of psychiatrist and pharmaceutical utilization.

Lessons Learned and Challenges Remaining

With only 4 years of managed care experience, the challenges facing Delta in seeking to provide a cost-effective, generous mental health benefit plan are in their earliest stages.

Lessons Learned

- Employers must recognize that mental illnesses and subclinical problems do exist in the workforce. Companies can realize significant benefits by supporting programs and health care plans that provide comprehensive diagnosis and treatment for such illnesses.
- Employers should consider the specific needs of their employees carefully when purchasing benefits. Because standard HMO plans limit the administrative costs inherent in individualization, employers must be persistent to obtain the benefits they desire for their employees. For example, FAA regulations require airline pilots with substance abuse problems to receive inpatient treatment to fly again. As a result, Delta had to be certain that CIGNA would cover such treatment.

Challenges Remaining

- Delta is working to improve employee knowledge of and access to its EAP. Employees worry that revealing a problem to an EAP counselor may hurt their employment or may result in decreased benefits. Furthermore, the stigma associated with seeking mental health treatment persists.
- As the EAP and managed care plans have developed, Delta has begun to study their impact. The company needs to improve its data gathering and monitoring systems. It must evaluate the effects of mental health care on productivity, absenteeism, and disability.
- Delta faces several possible challenges resulting from changes in both the health care field and the corporate climate. Increasing regulatory and financial pressures in the managed care industry may force CIGNA to eliminate its on-site presence and preferred treatment of Delta or to reduce overall administrative staffing levels. Delta's corporate climate continues to change; new leadership may place less emphasis on comprehensive mental health coverage.

C. Eli Lilly and Company

Company History / Profile

Based in Indianapolis, Indiana, Eli Lilly and Company conducts drug research and sells pharmaceuticals, medical instruments, diagnostic tools, and animal health products throughout the world. Founded in 1876, Eli Lilly has experienced its most significant growth in the past 20 years. The company's nearly 30,000 worldwide employees include

more than 14,000 in the United States, primarily in the Indiana area.

Factors Influencing Company's Decision to Provide Comprehensive Benefits

As a company with considerable psychotropic pharmaceutical sales, Eli Lilly has a significant investment in neuroscience and mental health. Recognizing that comprehensive mental health benefits foster productivity and help recruit and retain employees, the company is also dedicated to providing such care to its employees. Data from a 1998 report suggest that Lilly has profited as a corporation because of its benefits plan decisions. Lilly ranks among top pharmaceutical employers in terms of the employer-paid value of its health care benefits. This value coincides with average employee copayments and deductibles lower than those offered by comparable organizations (Hewitt Associates, 1998).

Mental Health Benefits

Description of Benefit Options

Unless they have waived it, all employees receive mental health coverage through the company's Uniform Mental Health Benefit, an internally managed indemnity plan. Since 1995, employees have had a choice between an indemnity plan, referred to as Lilly Health, and various HMOs for physical health care. In 1999, approximately 60 percent of employees enrolled in the indemnity plan, and 40 percent enrolled in managed care. Tables 6–8 give details about the health care plans.

Eli Lilly's health benefits have been transformed as the company, responding to a growing workforce, has begun to develop managed care options for its employees. Before 1992,

Table 6: Summary of Benefit Structure: Uniform Mental Health Benefit				
Service	Copayments	Coinsurance	Annual/Lifetime Dollar Limits	Annual/Lifetime Day/Visit Limits
Deductible	No deductible			
Out-of-pocket maximum	No maximum			
Inpatient mental health	No copayment	100% for facility; 90% for provider	No limits	60 per year, 180 per lifetime
Outpatient mental health (nonintensive)*	No copayment	80%	No limits	50 per year, no lifetime limit
Intensive outpatient care **	No copayment	100% for facility; 80% for provider	No limits	30 days consecu- tively per year, no lifetime limit
Intensive nonresidential (partial inpatient)***	No copayment	100% for facility; 80% for provider	No limits	25 days consecu- tively per year, no lifetime limit
Nonhospital residential	Not offered	Not offered	Not offered	Not offered
Crisis-related	Not offered	Not offered	Not offered	Not offered

* Initial contact with providers, diagnostic services, and preliminary care in an outpatient setting.

** A 3 day per week, 3 hour per day model including group therapy, psychoeducation, and family therapy. This model, occasionally used as a transitional phase from partial inpatient services in treating acute emotional problems, offers services through a multidisciplinary provider team.

*** Services based on a 5 day per week, 6 hour per day model; the program includes individual, group, and family therapy and uses a multidisciplinary provider team.

Table 7: Summary of Benefit Structure: Lilly Health Plan (physical health only)				
Service	Copayments	Coverage Levels	Annual/Lifetime Dollar Limits	Annual/Lifetime Day/Visit Limits
Deductible	\$200 per person, \$500 per family			
Out-of-pocket maximum	6% of annual salary (does not include mental health costs)			
Inpatient physical health	No copayment	100% for facility; 90% for provider	No limits	No limits
Outpatient physical health	No copayment	80% for provider; 100% for outpatient surgery	No limits	No limits

<i>Service</i>	<i>Copayments</i>	<i>Coverage Levels</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	No deductible in-network; \$500 out-of-network per person, \$1,250 out-of-network for family			
Out-of-pocket maximum	6% of annual salary (does not include mental health costs)			
Inpatient physical health	\$25	100% in-network; 80% out-of-network	No limits	No limits
Outpatient physical health	\$5	100% in-network; 80% out-of-network	No limits	No limits

Lilly offered only the Lilly Health indemnity plan, which included mental health coverage. In 1992, the company contracted with United Behavioral Health (UBH) to institute an EAP to provide worksite counseling and to manage the mental health component of the Lilly Health Plan. Physical health benefits remained under the Lilly Health Plan. The EAP served as a gatekeeper to mental health services. After 1 year, however, as a result of employee dissatisfaction with referrals through the EAP, the company reintegrated the mental health benefit into the indemnity plan. UBH continues to operate the EAP.

Eli Lilly first ventured into managed care in 1995, offering employees a choice of the Lilly Health Plan or various HMO options. In Indiana, the company has maintained full-risk contracts with the same four HMOs (Arnett, CIGNA Healthcare/Healthsource, M Plan, and Prudential) since 1995. Prudential also serves employees outside Indiana. Each HMO plan provides identical physical health benefits negotiated specifically for Lilly employees, with monthly premiums of \$5 for a single employee or \$10 for family coverage. The Lilly Health Plan requires monthly premiums of \$15 for an employee or \$35 for a family (Eli Lilly & Company, 1999).

When Lilly began the transition to managed care, the company's benefits administrators were concerned about the vendors' ability to provide quality mental health care. As a result, the company decided to retain responsibility for mental health coverage by establishing and managing a uniform benefit under which all Lilly employees could receive services. The plan offers the same coverage level as the indemnity plan but waives the indemnity plan's deductible, making the mental health benefit richer than any physical health benefits under either the managed care or Lilly Health Plan option.

A carve-out pharmacy coverage offers a uniform benefit for both managed care and indemnity plan enrollees. Administered by PCS, the pharmacy plan includes an open formulary with a 20 percent copayment for both generic and name-brand drugs. Further, all Eli Lilly pharmaceuticals are free of charge. These benefits are available at any pharmacy. PCS also operates a mail-order pharmaceutical service requiring a \$20 copayment for name-brand drugs, a \$5 copayment for generic drugs, and no copayment for Lilly drugs. The company places no restrictions or caps on drugs for the treatment of physical or mental conditions.

Employee Assistance Program

The EAP, managed by UBH, offers a 24-hour toll-free telephone line for confidential psychological counseling and three free visits with community-based psychologists. As an indemnity plan, the Uniform Mental Health Benefit ensures continuity of care, enabling patients to see a provider of their choice for EAP visits or for mental health benefit services. Mental health benefits are available without precertification or an EAP referral.

Benefit Management

Eli Lilly's Corporate Health Services Division operates the Lilly Health Plan and Uniform Mental Health Benefit and oversees the EAP, the pharmacy, and the contracted HMOs. By centralizing benefits administration in one division, Lilly has been better able to manage its own health plan, to respond more effectively to employee dissatisfaction, and to increase on-site services. The company's mental health coverage reflects the corporate philosophy to help employees balance professional life and personal life.

This employee-centered philosophy also is visible in the company's relationships with vendors. The company strives to guarantee that plans offer high-quality health care. For example, when dissatisfied with UBH's mental health services, Eli Lilly reintegrated the benefit into the indemnity plan. At each worksite, the company employs full-time patient advocates who help employees navigate the claims process.

Key Program Components / Best Practices

- Graduated alternatives to outpatient care ensure appropriate levels of service.

Eli Lilly provides three graduated levels of outpatient care. Nonintensive outpatient treatment includes provider evaluation, diagnosis,

and preliminary care. Intensive outpatient treatment with a focus on rehabilitation involves care to individuals with chemical and alcohol dependency problems. The program, operating 3 days per week, 3 hours per day, provides group therapy, psychoeducation, and family therapy. This model, occasionally used as a transitional phase from partial inpatient services for acute emotional problems, offers services through a multidisciplinary provider team. Partial inpatient care provides an intermediate level of outpatient treatment to assist patients with problems too acute for conventional outpatient therapy. With 5 day per week, 6 hour per day services, the program includes individual, group, and family therapy and uses a multidisciplinary provider team. Employees must have precertification for inpatient and partial inpatient care.

- Worksite services offer additional outlets for care.

Eli Lilly is committed to expanding its worksite services for mental health counseling. Each Lilly office has two full-time, on-site clinical psychologists who provide free, unlimited evaluation, treatment, and education. Services include individual or group consultations, group educational therapy sessions (usually related to enhancing group working dynamics, managing stress, or responding to traumatic personal events), and on-site educational seminars (usually surrounding mental health concerns like depression awareness, work/life challenges, and teenage mental health).

According to Lilly, on-site staff have averaged 52,000 visits per year. Utilization has risen both as availability has expanded and as employees find on-site providers to be a more efficient use of their own time.

- **Work/life initiatives attempt to strike balance between work and home life.**

Consistent with Eli Lilly's holistic approach to mental health care, the company has implemented an evolving set of "work/life initiatives" to create a corporate culture that values a balance between home and workplace responsibilities, according to CEO Sidney Taurel (Lilly CEO, 1999). Services include two child care centers; adoption assistance; flexible work arrangements; paid leaves for maternity, paternity, and adoptive and foster parents; elder care consultation and referral services, including support and information-sharing groups; and financial planning and investment services.

- **Residential schools benefit helps children with severe emotional problems.**

As part of its mental health benefit, Lilly provides coverage for intensive, 24-hour structured residential care for dependent children ages 6 to 22 with a significant history of emotional problems. The program offers mental health care and an on-site educational curriculum coordinated with the local public school system. The benefit has no deductible and is exempt from the company's out-of-pocket maximum; coverage is limited to \$50,000 lifetime.

- **Global Incident Team coordinates crisis response.**

Lilly maintains a Global Incident Team to coordinate company-wide response to critical incidents that could affect the safety of the workforce or the surrounding community. This team works to expedite access to health providers and other resources. One key component of the team is mental health staff and psychological crisis counselors who provide timely mental health services for employees operating under crisis conditions.

Employee Satisfaction / Performance Data

Eli Lilly surveys 3,000 of its plan enrollees each year to get their feedback regarding health benefits. The survey asks employees to rate the quality and accessibility of care, administrative response, and customer service. The Corporate Health Services Division collects results, which, along with claims and clinical data, inform internal benefit structure and management decision making. Recent findings suggest that enrollees are generally satisfied with the HMOs and the Lilly Health Plan. The company does not collect data specific to satisfaction with mental health benefits.

In January 1999, Eli Lilly established an Absence Coordinator position to track employee absenteeism. Eli Lilly hopes to understand the duration and causes of absenteeism to help create better employee services. Currently, if an employee misses more than 1 week of work or receives complicated medical treatment, a worksite physician or psychologist reviews the treatment plan and monitors the employee's progress. Although complete data are not yet available, initial findings suggest that adequate mental health care has reduced absenteeism.

Lessons Learned and Challenges Remaining

Eli Lilly has identified several key lessons learned to date and recognized specific areas in which challenges remain.

Lessons Learned

- **Design benefits to help employees balance their home and professional lives.**
- **Recognize that employee benefits play a role in employee recruitment and retention in a changing corporate environment. Flexibility and responsiveness in benefit design and redesign permit a corporation**

to react to the mental and physical health needs of a growing workforce.

- Recognize the advantages of a uniform mental health benefit; realize that a company can successfully retain control of its benefits.
- Ensure that contractors understand the corporate philosophy underlying the mental health benefits being offered. Without a clear perspective, contractors may try to reduce costs by denying or reducing mental health services. Clarifying the scope of work for vendors is key.

Challenges Remaining

- Eli Lilly continues to encourage utilization of work/life initiatives, on-site care, and EAP services among employees and to increase awareness about benefits among dependents and retirees.

D. Fannie Mae Corporation

Company History / Profile

The Federal National Mortgage Association, also known as Fannie Mae, is a private, shareholder-owned company that purchases mortgages from primary lenders. Under a congressional charter in 1938, Fannie Mae operates a secondary mortgage market to increase money available for new home mortgages. In 1968, Fannie Mae became a private, self-sustaining corporation. Since this conversion, Fannie Mae has become number 26 on the Fortune 500 with 1998 revenues of \$31.5 billion. Based in Washington, D.C., Fannie Mae has 3,800 employees in its offices throughout the Nation.

Factors Influencing Company's Decision to Provide Comprehensive Benefits

Fannie Mae recognizes that employee benefits promote recruitment, productivity, and retention. The company has developed a comprehensive set of fringe benefits in an effort to remain an industry leader. For example, in addition to generous 401(k) and stock purchase plans, Fannie Mae offers some unique financial benefits, including housing assistance programs and reimbursement for adoption expenses. The company also offers emergency child care, an elder care program with case management and other services for parents and relatives of employees, and a variety of flexible work options, including job sharing and telecommuting.

Mental Health Benefits

Description of Benefit Options

Fannie Mae offers several health coverage options: a PPO, two HMOs in each region, and a catastrophic indemnity plan. About 54 percent of employees are enrolled in the PPO, approximately 35 percent in an HMO, and 3 percent in the catastrophic plan. The remaining 8 percent have waived coverage. Employees choosing the catastrophic indemnity plan or waiving coverage often are covered under a spouse's health plan; they select these lower cost options so that they can purchase specialty coverage, such as vision care.

Fannie Mae contracts with Kaiser Permanente, HMO-Illinois, and Aetna U.S. Healthcare for HMO coverage. Aetna also manages the PPO and catastrophic indemnity plans. The company covers 100 percent of premiums for single employees and 60 percent of premiums for dependents, including spouses and domestic partners as well as natural, adopted, or step-children. Fannie Mae self-

insures for all coverage options. Because most employees participate in the PPO, this case study focuses on that benefit option. Tables 9–12 outline benefits provided by each option.

Benefits under each plan include some restrictions. In the PPO, mental and inpatient physical health benefits operate through a gatekeeper. Although mental health patients must obtain precertification from Magellan Health Services, Fannie Mae places no limits

on services approved by Magellan. Out-of-network rates apply to unapproved services. This gatekeeper system is designed to ensure appropriate utilization, allowing Fannie Mae to continue providing unlimited benefits. The company places a priority on unlimited care for patients in need. Inpatient physical and mental health care face the same restrictions.

Since January 1, 1998, Fannie Mae has contracted with National Prescription Administrators to manage the PPO plan's

Table 9: Summary of Benefit Structure: PPO Plan				
Service	Copayments	Coinsurance	Annual/Lifetime Dollar Limits	Annual/Lifetime Day/Visit Limits
Deductible	\$0 in-network and \$125 to \$500 per family member out-of-network (dependent on income) for both physical and mental health care			
Out-of-pocket maximum	Salary less than \$30,000 Individual: \$800 in-network; 4% of salary out-of-network Family: \$1,200 in-network; 6% of salary out-of-network Salary \$30,000 to \$50,000 Individual: \$1,100 in-network; 4% of salary out-of-network Family: \$1,600 in-network; 6% of salary out-of-network Salary \$50,000 or more Individual: \$1,400 in-network; 4% of salary out-of-network Family: \$2,000 in-network; 6% of salary out-of-network			
Physical Health				
Inpatient	No copayment	90% in-network; 80% out-of-network	No limits	No limits
Outpatient	\$5	100% in-network; 80% out-of-network	No limits	No limits
Mental Health				
Inpatient	No copayment	90% in-network; 80% out-of-network	No limits	No limits
Outpatient	No copayment	75% in-network; 50% out-of-network	No limits	No limits in-network; 50 visits per year out-of-network
Nonhospital residential (subject to referral and precertification)	No copayment	90% in-network; 80% out-of-network	No limits	No limits
Intensive nonresidential (partial hospitalization)	No copayment	75% in-network; 50% out-of-network	No limits	No limits in-network; 50 visits per year out-of-network
Crisis-related	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient

Table 10: Summary of Benefit Structure: Aetna HMO Plan				
Service	Copayments	Coinsurance	Annual/Lifetime Dollar Limits	Annual/Lifetime Day/Visit Limits
Deductible	No deductible for either physical and mental health care			
Out-of-pocket maximum	No maximum for either physical and mental health care			
Physical Health				
Inpatient	No copayment	100%	No limits	No limits
Outpatient	No copayment	100%	No limits	No limits
Mental Health				
Inpatient	No copayment	100%	No limits	30 days per year
Outpatient	\$0, visits 1–5; \$5, visits 6–30	100%	No limits	20 visits per year
Nonhospital residential (subject to referral and precertification)	No copayment	100%	No limits	30 days per year
Intensive nonresidential (subject to referral and precertification)	\$0, visits 1–5; \$5, visits 6–30	100%	No limits	20 visits per year
Crisis-related	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient

pharmacy benefit. The plan requires a \$5 copayment for generic drugs or doctor-required name-brand drugs at participating pharmacies (or \$5 for a 3-month mail order supply). Fannie Mae covers medication purchased in out-of-network pharmacies at 80 percent. To receive a name-brand medication not specified by a doctor, a patient pays the cost difference between the name-brand medication and its generic counterpart. No distinctions are made between physical and mental health pharmaceuticals.

Employee Assistance Program

Fannie Mae has contracted with Value Options, Inc., to operate its external EAP since the program's inception in 1987. The

program, providing assistance with mental health, substance abuse, financial, and legal problems, most often deals with marital and family conflicts. Employees can receive up to seven sessions per incident. In 1998 and 1999, between 7 and 9 percent of Fannie Mae employees used the EAP.

Although the EAP has no on-site presence, Fannie Mae attempts to increase awareness and improve utilization. The company does not have an official structure enabling managers to refer employees to the EAP; managers informally pass information along when necessary. Fannie Mae also offers seminars and lunchtime programs during which employees can learn more about a variety of topics, including the EAP.

Table 11: Summary of Benefit Structure: Kaiser Permanente HMO Plan				
Service	Copayments	Coinsurance	Annual/Lifetime Dollar Limits	Annual/Lifetime Day/Visit Limits
Deductible	No deductible for either physical and mental health care			
Out-of-pocket maximum	No maximum for either physical and mental health care			
Physical Health				
Inpatient	No copayment	100%	No limits	No limits
Outpatient	\$5	100%	No limits	No limits
Mental Health				
Inpatient	No copayment	100%	No limits	45 days per year
Outpatient	\$20	100%	No limits	No limits
Nonhospital residential (subject to referral and precertification)	No copayment	100%	No limits	45 days per year
Intensive nonresidential (subject to referral and precertification)	\$20	100%	No limits	No limits
Crisis-related	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient

Benefit Management

Fannie Mae administers its health benefits through three internal groups: the Compensation and Benefits Department, the Human Resources Service Center, and the Health and Work Life Center. The Human Resources Service Center handles everyday administration of the benefits plan and operates a hotline for employee questions or complaints about their benefits. Issues about the benefits policy go to the Compensation and Benefits Department, which acts as plan purchaser, monitors plans' performance, and manages official communication with vendors. Fannie Mae reviews its health insurance vendor contracts annually.

While benefits administrators refrain from direct involvement with managed care vendors, the consulting psychiatrist often works

as a direct employee advocate. Through case management responsibilities, the psychiatrist monitors providers and MCOs. The consulting psychiatrist spends approximately 10 to 15 percent of his or her time seeking precertification for treatment or questioning denials of coverage.

Key Program Components / Best Practices

Under the authority of the Health and Work Life Center, Fannie Mae encourages wellness through initiatives designed to promote healthy living and to help employees balance home and work life. The Center also provides limited treatment through staff nurses and part-time, on-site physicians, one specializing in primary care and one in mental health.

Table 12: Summary of Benefit Structure: Catastrophic Indemnity Plan				
<i>Service</i>	<i>Copayments</i>	<i>Coinsurance</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	\$2,500 for either physical and mental health care			
Out-of-pocket maximum	\$2,500 for either physical and mental health care			
Physical Health				
Inpatient	No copayment	100%	No limits	No limits
Outpatient	No copayment	100%	No limits	No limits
Mental Health				
Inpatient	No copayment	100%	No limits	No limits
Outpatient	No copayment	50%	No limits	50 visits per year
Nonhospital residential (subject to referral and precertification)	No copayment	100%	No limits	No limits
Intensive nonresidential (subject to referral and precertification)	No copayment	50%	No limits	50 visits per year
Crisis-related	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient	Same as inpatient if hospitalized; if not, same as outpatient

- **On-site psychiatrist acts as lead mental health resource.**

One of Fannie Mae’s direct attempts to improve mental health care came 8 years ago when it hired a part-time, on-site psychiatrist.

The psychiatrist meets with employees in a nonclinical setting, gives advice, and makes referrals to the EAP or the benefits plan; he conducts approximately five consultations (direct contact, review of records, and telephone review of regional cases) each week. An employee can consult the psychiatrist for any reason and as often as needed. The psychiatrist also serves as a case manager for mental health care, maintaining contact with the provider to ensure appropriate access to and quality of treatment. Another level of employee contact involves resolving health-related workplace issues

through a collaborative effort including the treating physician; the human resources, Health Services, and Legal staffs; and Fannie Mae management.

The consulting psychiatrist also works as part of an integrated team with Security, Legal, Health Services, Human Resources, and senior management to respond to potential acts of workplace violence. In addition, he consults with the corporation concerning its mental health benefits and provides feedback on the EAP and the mental health benefits plan. The current psychiatrist’s interest in the integration of mental and physical health care has led to an increased awareness by Fannie Mae leadership of the need to provide comprehensive mental health benefits and to facilitate the integration with physical health care.

- The Partnership for Healthy Living program assesses employee health.

The Partnership for Healthy Living program, operated by HealthOne, Inc., provides all Fannie Mae employees with free annual health assessments, including medical and behavioral health screenings. Participants complete a comprehensive health questionnaire and receive a Personal Wellness Profile outlining their overall wellness and ratings in specific areas. The Partnership for Healthy Living stresses a holistic approach to wellness. In addition to physical health and lifestyle questions, the questionnaire addresses behavioral-health-related topics such as substance abuse, stress, depression, anxiety, suicide, coping, social support, social activity, and violence. The profile also includes general and personalized information to educate employees about controlling substance abuse, managing stress, and improving mental health. After receiving the profile, participants can attend group counseling sessions that address the results of the screening. Fannie Mae encourages employees to complete the assessment and counseling session, offering a “healthy living” vacation day as an incentive.

- Educational programs increase awareness about wellness issues.

The Health and Work Life Center sponsors a variety of educational programs on topics such as stress reduction, depression, alternative medicine, ergonomics, and other wellness and mental health concerns. Furthermore, specific programs offer information sessions to familiarize employees with their services. The on-site psychiatrist takes an active role in some of these educational programs.

Employee Satisfaction / Performance Data

Fannie Mae uses several formal and informal instruments to assess its health benefits. The company monitors customer satisfaction with provider service through performance measures such as telephone hold times and timeliness of claims payments. Fannie Mae evaluates EAP success quarterly, looking at utilization, cost, and number of cases resolved. The consulting psychiatrist provides input into the comparison of the current vendor to competitors’ services.

Both Fannie Mae and its managed care vendors conduct employee satisfaction surveys. Fannie Mae also assesses employee satisfaction through its hotline (operated by the Human Resources Service Center) and tracks employee complaints and responds to issues that are raised frequently.

Benefits staff, Health and Work Life Center employees, and the consulting psychiatrist note less concrete performance measures such as general perceptions of employee satisfaction or direct feedback from employees, the EAP, and colleague physicians. The Health and Work Life Center staff tracks sick leave, short- and long-term disability, and workers’ compensation.

The most prevalent problems reported relate to the provider network. Aetna’s merger with U.S. Healthcare created network turnover, forcing a number of employees to change providers or to pay additional fees to see the providers of their choice. Fannie Mae is concerned about access to mental health services under the managed care plans. Although the company recognizes the value of a gatekeeper, it also believes that precertification can pose a significant barrier to care, requiring a prospective patient to place a telephone call and pass through numerous menu levels of electronic telephone management.

Fannie Mae plans to design an instrument to track the relationship between utilization of mental health care service and productivity. By measuring clinical, financial, and attendance data as well as the impact of care on the relationship between managers and employees, the outcome of care at work, and the impact on the patient's family, Fannie Mae will get a more systematic assessment of the effects of mental health benefits.

Lessons Learned and Challenges Remaining

Fannie Mae's focus on mental health has resulted in an increased awareness of the direct relationship between overall wellness and employee productivity. Through its benefits plan and programs to maintain employee physical and mental health, Fannie Mae has learned valuable lessons and identified several remaining challenges.

Lessons Learned

- Employee well-being is affected by mental as well as physical health. Physical conditions may have underlying, comorbid mental illnesses. Furthermore, mental health problems generally are more prevalent than assumed; companies must provide diverse and effective treatment options for employees who need help.
- To ensure quality and accessible care under MCOs, a company must advocate on behalf of its employees. This interaction can come directly from the purchasing office or through a consultant, such as Fannie Mae's on-site psychiatrist. Official responses are more effective than individual complaints at enticing the MCO to cover specific treatments.
- Development of a comprehensive mental health benefits plan is an ongoing process; plan design is dynamic.

A company should monitor its mental health benefits and work to improve them often and proactively.

Challenges Remaining

- Fannie Mae is improving the integration of physical and mental health care. The company continues to study the impact of mental health on productivity, absenteeism (including short- and long-term disability), and employee well-being.
- Fannie Mae is working to ensure access to mental health care by becoming a more effective manager of providers and MCOs. The consulting psychiatrist provides case management of employee care; the company is working to streamline this process and to improve overall access to care.
- Fannie Mae hopes to end regional variations in its benefits plan by encouraging its HMOs to offer consistent benefits. For example, Maryland, Virginia, and District of Columbia employees all receive slightly different HMO mental health benefits because of varying State regulations.

E. Motorola

Company History / Profile

Motorola, an international communications company established in 1928, has undergone a significant transformation during the past 2 years. The 34th largest company in the United States, Motorola faced financial challenges in 1997–1998 that have had substantial effects on Motorola's employees. The company's financial losses led it to reduce U.S. operations by more than 20,000 employees; the Schaumburg, Illinois-based company now has 133,000 employees worldwide and 65,000 in the United States.

Factors Influencing Company's Decision to Provide Comprehensive Benefits

In the late 1980s, the Federal Government introduced legislation supporting drug testing in the workforce. As a result of this Drug Free Workforce (DFWF) legislation, Motorola embraced random drug testing before and during employment. Drug testing encouraged early identification of problems; therefore, Motorola recognized that providing benefit coverage for a wide range of diagnoses and treatment alternatives was a critical next step.

During the same period, Motorola's EAP sought to improve the quality and cost management of the behavioral health benefits plan design. Developed in 1979, the EAP had a profound influence on the company's philosophy of behavioral health care. The EAP examined quality of care, utilization, and cost data. In response to the DFWF policy, opportunities identified by the EAP, escalating health care costs, and decreasing employee satisfaction with health benefits, Motorola developed a comprehensive plan to foster employee well-being and productivity, thereby generating long-term cost savings.

The company's progress in the area of health benefits is evidenced in part by the national attention Motorola has received from its corporate peers and the Federal Government. In 1997, the company was invited to present its health plan to employers at a meeting of the National Managed Health Care Congress (Ceniceros, 1997). In 1998, The Health Project, a nonprofit health consortium, presented Motorola with a C.

⁸ This section is based on Motorola's "FACTS 99," the Motorola website (www.motorola.com), and the 1998 Summary Annual Report "Managing Change Positioning for the Future" from Corporate Communications.

Everett Koop National Health Award, honorable mention.⁸

Mental Health Benefits

Description of Benefits Options

Motorola currently provides three types of physical health benefit options for its employees:

- 1) *Health Advantage Plan*: a customized network of approximately 100,000 doctors, 900 hospitals, and 4,000 mental health care providers nationwide brought together by Motorola to form a PPO;
- 2) *Basic Medical Plan*: an indemnity plan with an open provider network; and
- 3) *Several HMO plans*.

The company provides uniform behavioral health benefits to all PPO and indemnity plan enrollees through a Mental Health and Chemical Dependency (MHCD) program.

Before 1995, approximately 33 percent of Motorola's employees enrolled in the company's HMO option and 66 percent in its indemnity plan. Employees received behavioral health benefits through these plans. Motorola embarked on a partnership with Private Healthcare Systems (PHCS) to create the PPO and the MHCD program. Consultants estimated that between 25 and 50 percent of Motorola's employee would enroll in the PPO during its first year. In fact, 58 percent of employees switched. In 1999, 70 percent of Motorola's employees chose the PPO, 17 percent chose an HMO, 6 percent chose the indemnity plan, and 7 percent

⁹ Motorola contracts with 23 HMOs nationwide, including Cigna, Kaiser, United Healthcare, Humana, and Aetna/US Healthcare. Because coverage of services varies according to HMO, specific benefit information could not be represented in a table format.

Table 13: Summary of Benefit Structure: MHCD Program				
Service	Copayments	Coinsurance	Annual/Lifetime Dollar Limits	Annual/Lifetime Day/Visit Limits
Deductible	No deductible for physical or mental health treatment			
Out-of-pocket maximum	\$2,000 single; \$2,500 family			
Inpatient behavioral health	No copayment	90% in-network; 50% out-of-network	No limits	No limits in-network; 10 days out-of-network
Outpatient behavioral health	No copayment	90% in network; 50% out-of-network	No limits	No limits in-network; 20 days out-of-network
Nonhospital residential (subject to referral and precertification)	No copayment	90% in network; 50% out-of-network	No limits	No limits in-network; 10 days out-of-network
Intensive nonresidential (partial hospitalization)	No copayment	90% in network; 50% out-of-network	No limits	No limits in-network; 10 days out-of-network
Crisis-related	Motorola treats emergency treatment exactly like inpatient or outpatient, depending on which one it is.			

waived coverage. Tables 13–15 present the specific benefits Motorola offers under the PPO and the indemnity option.⁹

Motorola provides coverage for full- and part-time employees and their dependents. PPO monthly premiums range from \$24 for a single employee to \$55 for a family, and indemnity plan premiums range from \$45 for a single employee to \$76 for a family. Although Motorola contributes the same amount for HMO coverage as it does for PPO coverage, most employees who select an HMO pay higher premiums than under the PPO.

Motorola contracts with an external network and medical manager to provide CallCARE, a utilization review program offering assistance and case management to Motorola employees. Employees must receive precertification from CallCARE for full coverage of inpatient physical and behavioral health care for employees.

Motorola also operates a prescription drug program for its PPO and indemnity plan enrollees. The program enables employees and their dependents to receive medications through either a retail network pharmacy or a mail-order service. Motorola encourages employees to use generic drugs unless the doctor or pharmacist recommends a name-brand medication. The plan requires an \$8 copayment for generic drugs and a \$16 copayment for name-brand pharmaceuticals. This copayment covers a 30-day prescription in a network pharmacy or a 90-day supply from the mail-order service. Motorola contracts with PHCS to administer pharmaceutical benefits.

Employee Assistance Program

Staffed by internal professional employees, Motorola’s EAP has operations throughout the world. The EAP is part of the Global Employee Consultation Systems (GECS), an

Table 14: Summary of Benefit Structure: Health Advantage Plan-PPO (physical health only)				
<i>Service</i>	<i>Copayments</i>	<i>Coinsurance</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	No deductible for physical or mental health treatment			
Out-of-pocket maximum	\$2,000 single; \$2,500 family			
Inpatient physical health	No copayment	90%	No limits	No limits
Outpatient physical health	\$10 for routine office visit	90%; 100% for routine office visit	No limits	No limits

Table 15: Summary of Benefit Structure: Basic Medical Plan—Indemnity Plan (physical health only)				
<i>Service</i>	<i>Copayments</i>	<i>Coinsurance</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	\$300 single; \$600 per family for both physical and mental health.			
Out-of-pocket maximum	\$3,000 single; \$4,000 per family for physical health and mental health			
Inpatient physical health	No copayment	80%	No limits	No limits
Outpatient physical health	\$10 for routine office visit	80%	No limits	No limits

organization with responsibility for the DFWF program, workplace violence strategy and policy, and systemic problem-solving structures. The GECS director and the director of global rewards and benefits report to the same supervisor, a system that encourages discussions and collaboration between the corporate benefits and EAP leadership.

In 1988, the EAP leadership team developed the strategy and vision for a global EAP organization. The team proposed to consult with and provide effective solutions to Motorola management, Human Resources, and employees to achieve maximum performance. A significant aspect of the new strategy involved the team influencing the design and delivery mechanism of the behavioral health

benefits. This strategy represented a departure from standard EAP practice of the time as the EAP did not want to act as the “gatekeeper” to benefits.

During the past decade, the EAP leadership has focused on remaining an internally staffed organization. The EAP staff serves groups, teams, and individual associates within the company. In addition to direct interaction with employees, the company’s EAP helps ensure the quality of behavioral health service through various management roles: helping develop the provider network, providing case management to referred patients, and coordinating worksite activities for services that are administered by both the behavioral health benefit and the EAP.

Benefit Management

Motorola actively manages much of its benefits program through the Benefits Administration Office. This office and the EAP take an active but nonrestrictive role in managing the PPO. Providers who have won the confidence of Motorola and PHCS must discuss patient progress with utilization review medical managers only after 20 visits (the average number of visits is eight).

Motorola also has become involved in monitoring its HMOs. The company has reduced the number of HMOs from 35 to 23 during the past 6 years and has frozen enrollment for HMOs that do not meet Motorola's standards of care. The company is concerned about HMO and provider compliance with its demands for increased access to behavioral health services and improved quality of care.

Key Program Components / Best Practices

- **Motorola uses employee feedback to help design its customized PPO.**

As part of its ongoing review of benefits programs in the early 1990s, Motorola conducted 150 focus groups with workers across the country to gain a better understanding of employee priorities and concerns regarding their health benefits. The company also reviewed data on benchmark programs and evaluated information from employee satisfaction surveys. Mirroring national trends, the company's employees reported dissatisfaction with 1) excessive paperwork burdens, 2) gatekeeper restrictions to services within HMO plans, 3) unexpected out-of-pocket costs, and 4) lack of preventive and well-baby care.

Employee feedback served as a driving force behind the company's decision to create its PPO option, which is unique because the company's Corporate Benefits and EAP man-

agement set the vision and strategy for network development and management and worked closely with PHCS to create the customized network. A key driver in network development was the desire to minimize micromanagement by screening providers with an extensive set of quality measurements; Motorola gave providers who met the standards flexibility in delivery of care through less restrictive utilization review.

Motorola identified potential providers through a variety of mechanisms, including claims data, recommendations from EAP staff and Motorola employees, and the network manager's provider preferences. Because the EAP had operated with Motorola since 1979, it had extensive knowledge of the behavioral health providers in various Motorola locations. The company also reviewed existing EAP providers and expanded the mental health network to include psychiatrists, psychologists, and licensed social workers.

Even after the establishment of the network, Motorola employees continue to have the opportunity to recommend specific providers (both medical/surgical and behavioral health) for inclusion. Inclusion is based on whether the provider meets the screening requirements.

- **Work/life initiatives improve overall employee well-being.**

Motorola believes it can improve the productivity and health of its workforce significantly by encouraging a supportive work environment for all employees. As a result, it has sponsored several initiatives designed to reduce stress in employees' lives.

In partnership with PHCS, Motorola operates disease management programs (called "Essential Quality of Life Programs") for employees and dependents facing chronic conditions, such as depression. These programs educate patients about their conditions

and methods of treatment, foster a healthy lifestyle, and encourage them to coordinate with physicians to follow the treatment and prescription regimens designed by clinical experts.

Motorola also offers a variety of additional programs designed to address employee concerns. The company's Milestones program, developed in response to employee focus groups, offers financial assistance for major life events. Motorola's Special Delivery program provides case management during pregnancy and free use of pagers for expectant parents. Motorola also helps parents with child care, reimbursing expenses incurred during in-home care for mildly ill children and offering on-site and near-site child care development centers.

- **Consolidation of behavioral health benefits ensures coverage.**

Motorola decided to consolidate its behavioral health benefits because of a corporate desire to offer uniform coverage guided by a consistent treatment philosophy across the covered employee population. Because employees generally do not anticipate the need for behavioral health benefits at the point of enrollment, they could neglect to select coverage. Consolidation offers the benefits without requiring employees to make a specific selection and permits the use of the benefit in a stigma-free environment if the need arises. All employees are automatically covered, no matter which plan they choose.

- **Motorola offers three paths of entry to the mental health benefit.**

The company's dedication to ensuring access to mental health care has resulted in three points of entry to the mental health network: the EAP, family physicians, and self-referrals.

Employee Satisfaction / Performance Data

Motorola has developed an extensive system to evaluate its benefits plan options. Since 1993, the company has used an assessment conducted by Towers Perrin to rate HMO performance. Motorola integrates these results to evaluate its HMOs based on the following criteria: clinical quality of care (35 percent), customer satisfaction (30 percent), financial management (20 percent), and accessibility (15 percent). Due to poor performance, specifically a decline in customer satisfaction and increased barriers to access, Motorola froze enrollment for two plans in 1998. Furthermore, the company distributes an HMO Report Card detailing plan ratings for each of the criteria to all employees.

Motorola has also evaluated its PPO as part of its annual Report Card. The results from the 1998 analysis show that the PPO received a score of 67.25, compared with the average HMO score of 49.03 (on a scale of 100). The PPO performs particularly well in the employee satisfaction component of this score. Ninety-four percent of enrollees reported overall satisfaction with the PPO, compared with 86 percent for the HMOs and 79 percent for the indemnity plan.

Motorola is also working with MEDSTAT, a health data consulting firm, to develop an information system for performance data. The system will include analysis of

- direct costs (medical claims, pharmacy benefit management costs, and other vendor costs);
- people-specific issues (quality of care, customer satisfaction, self-management, quality of life); and
- indirect costs (employee absence, productivity).

Lessons Learned and Challenges Remaining

Motorola has identified several key lessons learned from its experience providing comprehensive mental health benefits and recognizes specific areas in which the company must strive to meet challenges.

Lessons Learned

- Respond to employee concerns about the quality of behavioral health care. Using focus groups enabled Motorola to customize its provider network and behavioral health benefits plan to employee needs. Additional employee feedback led to quality-of-life programs.
- Encourage the “least intensive locus of care” approach by investing in alternatives to inpatient care, such as disease management, worksite programs, and outpatient options. Worksite programs capitalize on the convenience of on-site services for employees, while outreach and education increase understanding of appropriate care. Such programs result in greater access to and use of services and reductions in expensive inpatient costs.
- Partner with the EAP to take a key role in developing a high-quality behavioral health benefit and helping to coordinate care. The EAP is a unique resource for developing a behavioral health network of providers and facilities. It also has the expertise to partner with senior corporate management in designing the behavioral health benefit and in developing a myriad of employee programs.

Challenges Remaining

- Motorola faces continuing challenges in profiling providers and in precertification for inpatient care. Motorola also hopes to improve its overall health benefits by

enhancing its Essential Quality of Life Programs and broadening the scope of company-sponsored health risk assessment screenings.

- In developing its PPO plan, Motorola found its greatest challenge to be convincing medical providers and vendors that quality care is paramount. The company must clearly define its expectations and work with providers and vendors to meet them. Turnover within vendor organizations (because of mergers and other market changes) remains another barrier to quality care.
- The company believes the flexibility and sensitivity of an organization to respond to its employees’ needs with its own approach might be compromised if government regulates employers.

F. Company X

NOTE: This company has withdrawn its name from the study to avoid publicity during pending union negotiations. It participated fully throughout the process, provided researchers with all necessary information, and reviewed the case study. Other than the company name, no information has been altered. Some information concerning the company history and profile has been generalized to maintain confidentiality.

Company History / Profile

Company X is a large, multisite employer in the aerospace and electronics industry with a mixed product line including manufacturing, engineering, and construction components. It serves both government and commercial clients throughout the world. Company X’s 100,000 U.S. employees place it among the 50 largest employers in the country. The company has recently experienced rapid

growth, with significant merger and acquisition activity in the past 5 years. While the corporate consolidation and restructuring are now complete, the company continues to face the multitude of challenges inherent in forging one corporate culture from many different heritages.

In addition to consolidating its organizational structure, Company X had to integrate the disparate benefits from each of its component businesses. In designing a universal benefit, the company hoped to maintain overall equality and to provide the most comprehensive coverage possible. Uniting several benefit plans proved challenging because every plan had unique features; selecting the highest levels of coverage from each legacy plan proved cost prohibitive. The benefits administrators reached a compromise by maintaining aggregate employee benefits at or above their previous levels of coverage.

Factors Influencing Company's Decision to Provide Comprehensive Benefits

Company X recognizes that health care, and specifically mental health care, has a significant influence on employee satisfaction and productivity and therefore attempts to provide high levels of access to treatment, including on-site counseling when necessary, for employees and their families. The corporate leadership firmly believes that health care delivery must focus on investing in cost-effective systems that deliver a high quality of care.

Mental Health Benefits

Description of Benefit Options

Company X's recent benefits consolidation coincides with the company's transition to a unique, regional system of benefit administration. Before the mid-1990s, Company X

maintained fee-for-service health coverage. The rising price of health care shifted significant costs to the company because it failed to use the cost-containment strategies of managed care. Company X also faced a fragmented risk pool as each business sector purchased its own health benefits.

As it began operating under managed care, Company X decided to streamline its oversight and consolidate its regional purchasing power at the same time. The company perceived that contracting with one vendor to cover its entire workforce in a region presented a unique advantage in purchasing and administering benefits. Company X developed its first Regional Health Plan (RHP) in 1996 for New England and currently offers RHPs in eight regions where it has a large employee base and significant purchasing power. Each RHP offers two plan options: an HMO and a POS. While nearly three-quarters of Company X's 100,000 U.S. employees receive coverage from an RHP, the company does provide health coverage through several different arrangements. For example, approximately 15,000 employees living outside these main regions receive benefits via a national umbrella plan. This study will focus on those employees receiving RHP coverage. The following table provides specific information on one of Company X's RHPs.

Table 16: Summary of Benefit Structure: SAMPLE Regional Health Plan				
<i>Service</i>	<i>Copayments</i>	<i>Coinsurance</i>	<i>Annual/Lifetime Dollar Limits</i>	<i>Annual/Lifetime Day/Visit Limits</i>
Deductible	No deductible for both physical and mental health			
Out-of-pocket maximum	No maximum for both physical and mental health			
Physical Health				
Inpatient	\$100	100%	No limits in-network; \$3000 out-of-network	No limits
Outpatient	\$15	100%	No limits in-network; \$3000 out-of-network	No limits
Mental Health				
Inpatient	\$100 in-network; no copayment out-of-network	100% in-network; 50% out-of-network	No limits	60 days per year (90 per lifetime) in-network; 30 days per year (10 per lifetime) out-of-network
Outpatient	\$15 in-network; no copayment out-of-network	100% in-network; 50% out-of-network	No limits	26 visits per year
Nonhospital residential	\$100 in-network; no copayment out-of-network	100% in-network; 50% out-of-network	No limits	Counts toward inpatient limits
Intensive nonresidential	\$100 in-network; no copayment out-of-network	100% in-network; 50% out-of-network	No limits	Counts toward inpatient limits
Crisis-related	\$100 in-network; no copayment out-of-network	100% in-network; 50% out-of-network	No limits	Counts toward inpatient limits

In addition to simplifying benefits through regional management, the company has recently consolidated all the legacy benefits of its subsidiary companies into one Unified Benefit Plan. These unified benefits vary significantly because of differences between RHPs. Furthermore, although all employees in a region have the same plan, it does not necessarily provide uniform coverage across the region because of differences in State mandates. Because Company X is fully insured for its RHPs, it does not receive ERISA preemption and must comply with sometimes vastly different State regulations (e.g., mental health parity laws).

Company X remains dedicated to developing comprehensive physical and mental health benefit options; most RHPs offer identical cost-sharing requirements for physical and mental health but have more restrictive annual day/visit limits for mental health coverage. Furthermore, full coverage for mental health care requires precertification from the EAP. Prescription drug coverage, 100 percent with a \$5 copayment for generic drugs and a \$5 copayment plus the cost difference for name-brand drugs, does not vary for physical and mental health. Company X offers benefits to full- and part-time employees, their spouses, and their children.

All but one of Company X's RHP vendors take responsibility for mental health coverage. Prudential, which operates the Texas RHP, carves out its mental health benefit to Magellan. In Texas, Magellan also operates the EAP. Company X contracts with United Behavioral Health to provide EAP services for the remaining 63,000 employees covered under the RHPs.

Employee Assistance Program

Company X believes its EAP serves a valuable purpose by providing early intervention and increasing access to mental health care. Employees can receive up to eight sessions annually for each specific incident. Company X ensures that its vendors conform to this eight-session model and share the vision that an EAP should provide an additional path designed to encourage employees to access mental health care. While 50 to 70 percent of EAP users are successfully treated within the eight sessions offered by the EAP, Company X strongly encourages its EAP providers to refer patients to the mental health network. Although employees must receive precertification from the EAP before accessing the mental health benefit, Company X prevents its vendors from using the EAP to restrict access to necessary services.

Following the model that an EAP should facilitate mental health care utilization, the EAP treats both traditional psychiatric conditions and V-Codes, which are problems such as grief or marital difficulties that do not meet DSM-IV criteria. Company X also requires the EAP to provide services to all employees and family members whether or not they purchase health benefits. The company believes the wellness of others in the household directly affects an employee. Consequently, making the EAP available to every-

one in the household proves the most effective method of assisting the troubled family member and returning the employee to full productivity.

Although Company X contracts with external vendors, EAP counselors provide on-site services in some locations. Company X has found this on-site availability to be very effective in reaching employees who would not otherwise use the EAP. Employees who prefer to see a counselor off-site retain that option at all locations. Approximately 5 to 10 percent of Company X's employees access the EAP every year.

Benefit Management

When Company X ushered in managed care during the 1990s, it recognized that its industry experience represented an excellent source of knowledge about procuring contractors through competitive bidding. Company X modified these practices to develop a procurement system for MCOs based on a single-contractor purchasing strategy with competitive bidding. Company X solicits proposals from vendors and evaluates them using the following criteria:

- *Provider access:* provider network (hospitals and physicians), geographic access, percentage of open panels, referral circles, degree of continuity/network disruption, and care transition;
- *Clinical quality:* National Committee for Quality Assurance accreditation, HEDIS measures, disease management programs, formulary status, provider profiling, mental health and substance abuse delivery, and intense case management;
- *Administrative capability:* member services, claim processing, account management, Y2K compliance, and third-party administrator interface; and

-
- *Financial:* plan stability, market share, provider contracting, multiyear versus single year, rate assumptions, premiums and working rates, and performance guarantees.

After selecting several vendors as finalists, Company X's benefits managers visit each MCO to discuss clinical care and management issues more directly and examine the company's administrative capability firsthand.

Consolidating its purchasing power in each region enables Company X to negotiate favorable contracts that provide high levels of service to all employees. Operating longer-term (3- to 5-year) contracts with RHP vendors limits administrative expenses incurred in the rebidding process and makes Company X's annual costs more predictable. The company also recognizes that long-term contracts have significant advantages; a long timeframe enhances the MCO's ability to meet Company X's goals.

Although Company X contracts with MCOs on a fully insured basis, the company sees itself as an active benefits manager. For example, Company X analyzed employee usage data and held meetings with the primary care physicians (PCPs) that its employees used most frequently. By speaking with these physicians about access to mental health care, the company gained a better sense of its employees' needs. After an employee survey revealed a lack of specialists in one region, the company initiated community meetings with other employers to help ameliorate the shortage.

Company X also meets regularly with its EAP vendors to discuss EAP operation. Company X has worked diligently with United Behavioral Health to ensure the vendor understands Company X's eight-session model and its conception of the EAP as a path to services.

In addition to individual management, Company X participates in the Massachusetts Healthcare Purchaser Group (MHPG), a conglomeration of employers brought together to address cost and quality issues with managed care. The coalition of 60 public and private health care purchasers representing over 2 million New England residents works in four main areas: cost, quality, education and member support, and public policy. The consortium issues annual "cost challenges" to MCOs, in an attempt to limit increases in premiums, as well as a Rate Analysis Report detailing how plans spend the purchasers' money. It also evaluates health plans through two instruments: a Comprehensive Plan Evaluation (including total value, quality, cost, organizational stability, and member services indicators) and a Guide to Health Plan Performance, an annual report card on quality of care and member satisfaction. The MHPG recently designed an HMO survey examining five areas of health plan quality: mental health, prescription drugs, customer service, hospital and doctor relations, and management of chronic illnesses (Pham, 1999).

Key Program Components / Best Practices

Company X's health benefits include several innovative features, many of which relate to the company's proactive approach to increasing access to mental health care.

- **Partnerships provide innovative physical and mental health care.**

Company X's use of only one RHP vendor per region facilitates the development of a relationship between the company and the MCO. By focusing on a small number of RHPs, Company X can devote time to establishing these relationships. Company X's

partnerships have yielded concrete improvements in employee mental health care.

Company X's regional delivery system makes it an ideal candidate to participate in pilot programs because it has a large group of geographically localized employees. Its long-term contracts also ensure a continued employee base for the study. In such situations, Company X employees receive specialized and focused treatment and the vendor has the opportunity to evaluate specific interventions. In Massachusetts, for example, Company X has developed a partnership with Blue Cross/Blue Shield to provide integrated co-case management (physical and behavioral health) since 1997. Members diagnosed with cancer, heart disease, eating disorders, or other illnesses that indicate potential improvement from treating comorbid psychiatric conditions such as depression or anxiety can receive this integrated co-case management. The process ensures that the treatment team actively communicates and collaborates, resulting in integrated, cost-effective, and improved care for the member.

- **Company X facilitates early intervention through supervisor training.**

Because supervisors interact with employees daily, Company X hopes they can provide a first line of limited support for mental health problems. The company offers extensive supervisory training primarily focused on providing employees with access to support and helping them receive treatment through the EAP or the benefits plan.

- **A comprehensive response moderates negative impacts of critical incidents.**

The company offers a variety of services in the wake of critical incidents, such as natural disasters that affect employees, on-site injuries or deaths, and other events that serve

as a source of employee distress. For example, the Columbine High School shootings involved the children of several employees. Company X provided immediate counseling services to employees, families, and others in the community. Because of its large presence in the area, Company X felt that the school was part of the Company X community and joined the large outpouring of support by sending mental health providers directly to the school. Workers from the external EAP also came on-site at the company's Denver area offices to offer counseling.

Employee Satisfaction / Performance Data

Company X operates extensive monitoring networks for its EAPs. Monthly reviews of employee satisfaction and quarterly meetings with the vendors enable the company to monitor the EAPs closely. The quarterly meetings focus on targeted performance indicators that Company X can compare to benchmarked data from other EAPs. Company officials also participate in an EAP roundtable, in which they share specific performance data, and in a national EAP group composed of representatives from Fortune 500 companies, which discusses model EAP practices and issues specific to EAP management.

Company X includes performance standards in all its RHP contracts. Every RHP conducts annual employee surveys and shares the results with Company X. Company X and the MCO then respond to any areas targeted by employees as requiring improvement. The company also examines several other types of performance indicators, including human resources staff surveys, utilization rates, telephone response rates, and claims payment timing.

Lessons Learned and Challenges Remaining

Company X has identified several key lessons learned from its experience providing comprehensive mental health benefits and recognizes specific areas in which the company must strive to meet challenges.

Lessons Learned

- Company X believes that health care delivery requires a regional approach. The company could not provide the same comprehensive and specialized benefits by contracting with one national carrier. No region is exempt from difficulties in relation to managed health care, but each region has specific and distinct issues.
- A purchaser must determine goals for its EAP. Company X believes that an EAP should increase access to care instead of act as a gatekeeper to limit access. A company must clearly communicate its preferred approach to EAP access at the beginning of any contract.
- Companies must develop adequate performance standards and must define those standards clearly. For example, Company X has had difficulties assessing utilization rates because vendors do not use consistent methodology in reporting these figures. Some EAPs report the total number of existing open cases while others calculate utilization through the number of new open cases. Using open cases may underrepresent the case load.
- The company believes its attempts at early intervention, including supervisory training and access to support or treatment before a problem becomes critical, have had sig-

nificant impacts on improving overall behavioral health.

Challenges Remaining

- Company X faces significant barriers to assessing the performance of mental health benefits. The company's pooled arrangement for employee leave does not differentiate between sick leave and vacation, making it impossible to link plan performance with productivity or absenteeism. Furthermore, benefits consolidation has created difficulties in integrating different payroll platforms, preventing the company from examining employee absence accurately. In the near future, Company X will be able to track employees with short- and long-term disability; the company currently has a system in which employees on disability receive case management and integrated mental health care if necessary.

IX.

Appendix D: Managed Care Organization Case Studies

A. American Psych Systems

Company History/Profile

American Psych System (APS), started in 1992, is a relatively young company among those specializing in the delivery of managed behavioral health services. The eighth largest managed MBHO in the country, APS provides managed behavioral health and EAPs to about 5.2 million covered lives in 24 markets.

In 1995, APS purchased CHS, a small New York MCO. In September 1998, APS purchased Principal Behavioral Health Care. By adding Principal's 2 million lives, APS achieved the critical mass necessary to turn a profit (Managed care, 1998). Generating approximately \$40 million in revenue in 1998, the company attributes much of its success to its investment in building partnerships with providers and developing technology that allows the company to focus on quality of patient care.

APS's primary customers include private and public sector HMOs, PPOs, indemnity plans, State and local governments, corporate employers, and unions. The largest portion of APS's business is generated from its HMO clients, which include Principal Mutual Life, Coventry Health Care, Mastercare, and Kaiser Permanente. APS's staff of about 200 employees provides the following products:

<i>Products</i>	<i>Percentage of MBHO Market Share</i>
Employee assistance programs	4.7%
Integrated EAP/managed behavioral health programs	0.2%
Managed behavioral health programs	2.7%
Managed behavioral health administrative services	2.3%
All products	2.4%

APS has created a niche in the marketplace by appealing to small and mid-size HMOs that are less interested in contracting with one of the largest conglomerates in the industry, such as Magellan. The company's motto, "Big enough to deliver, small enough to care," reinforces this market strategy. The typical HMOs that contract with APS share the following characteristics:

- are regionally based,
- award contracts to MBHOs in the \$5-\$10 million range,
- serve about 50,000 to 250,000 members, and
- demonstrate an interest in differentiating (in some cases through the mental health services they provide) their company from the major HMO players.

APS has established a 95 percent client retention rate and is seeking to tap into a significant share of the small to mid-size HMO market, which includes about 400 HMOs. APS reports that the majority of

larger HMOs are less attainable clients, primarily because many have already established their own behavioral health carve-outs.

Behavioral Health Benefits

Employers, HMOs, and public sector agencies are contracting with MBHOs for a range of services and programs, including EAPs, behavioral health benefit packages, administrative services only (ASO) contracts, and a combination of these services.

Employee Assistance Programs

APS markets its EAPs as an opportunity for clients to reduce unnecessary health care costs, while providing workers with greater access to short-term behavioral health benefits requiring no copayments, deductibles, or restrictions. APS notes that EAPs are particularly useful to companies employing a high number of “blue collar” workers because they often earn low wages and may not seek behavioral health services because of high copayments and deductibles in many standard benefit plans.

APS offers a number of EAP models including telephone, in-person, combined telephone/in-person, and integrated EAP/managed behavioral health programs. EAP components include

- 24-hour access to master’s-level staff counselors,
- problem assessment and assistance,
- on-site crisis response,
- program promotion,
- referral to community resources,
- connection to health benefits,
- training and education,
- legal assistance, and
- financial consultation.

Employees may seek assistance on their own or on the recommendation of their supervisors or coworkers. Individuals call case managers on the toll-free EAP line, receive a risk assessment based on a screening checklist, and then receive a referral to an appropriate provider based on physician specialty and geographic location.

Employees, as well as their spouses and dependents, use the EAP for a number of reasons including family or relationship problems, parenting difficulties, work-related problems, substance abuse, emotional or physical abuse, and grief and loss. Employees typically receive up to eight free visits; beyond that they are required to access benefits from their standard physical and behavioral health package.

APS’s EAP employee utilization patterns indicate that 40 to 50 percent of all employees who initiate a call to the toll-free EAP line make an appointment for an initial evaluation or outpatient visit. Many employees either receive help from the EAP or lose interest in pursuing counseling before completing the first five sessions. Those who complete five sessions, however, are likely to reach the eight-visit maximum. The company also reports that 50 to 75 percent of employees seeking help with their behavioral health problems from the EAP do not require a referral to services offered under a company’s behavioral health benefit package.

According to APS, when evaluating the success of an EAP, employers and HMOs consider a number of factors:

- whether utilization rates of the program are high (indicating employees are receiving better access),

- selection of providers in the network (some HMOs or employers require the MBHO to contract with specific providers),
- frequency and number of complaints they receive directly from employees,
- range and level of services offered, and
- number of positive health outcomes resulting from EAP utilization versus those that require referrals to other behavioral health benefits.

Behavioral Health Programs

The fastest growing business segment in the company, behavioral health programs (mostly private sector contracts) generate 93 percent of APS's revenue. APS employs an innovative structure using "core" and "anchor" provider groups who maintain a unique relationship with the organization (see below for detailed information). Its HMO clients require copayments from \$5 to \$25 per outpatient visit. APS reports benefit packages vary by HMO, but most include

- outpatient assessment and treatment (typically 20 to 30 visits),
- alternative care, such as partial hospitalization, intensive outpatient and day treatment programs,
- inpatient assessment and treatment (typically 20 stays),
- individual and group treatment,
- crisis intervention available 24 hours a day, 365 days a year,
- some integrated services with substance abuse, and
- treatment followup and aftercare.

For special needs populations, such as Medicare and Medicaid recipients, the company provides expanded services to address unique challenges faced by elderly and low-

income populations. For example, APS's Medicare programs include in-home evaluations and treatment, hospital and nursing home consolidation services, and psychopharmacology, and Medicaid clients receive wrap-around services.

APS's experience suggests that the most critical HMO concerns in contracting with an MBHO are whether the MBHO can ensure patient costs will not increase, keep the providers satisfied, and produce timely reports on pertinent patient utilization information. APS emphasizes that in examining the quality of a company's behavioral health benefits, it is important to look beyond the range or array of services and evaluate a number of criteria, such as accessibility to services, breadth and depth of network, and utilization management practices.

Administrative Services Only

APS can provide administrative services to MCOs, provider groups, and States. Currently, APS provides administrative services to five entities: PBHN Carolina-Charlotte ASO, Priority ASO, Mt. Sinai, Magna Care, and the State of Georgia.

The State of Georgia contracts with APS as an external quality review organization (EQRO) to conduct utilization management and review for approximately 1.2 million Medicaid eligibles. As the EQRO, APS is also responsible for provider training and quality improvement initiatives for Georgia's Clinic Option Providers systems, which furnish Medicaid mental health, mental retardation, and substance abuse services.

APS's administrative products include

- comprehensive clinical intake, including risk assessment and member benefit/eligibility review,
- utilization and quality management,

- claims processing and payment,
- management information and systems reporting,
- 24-hours-a-day, 7-days-a-week crisis assessment and intake,
- ongoing clinical review and treatment,
- discharge and aftercare planning,
- PCP integration and coordination of care,
- comprehensive continuum of care including in-home evaluation and treatment, hospital and nursing home consultation services, geriatric specialists, developmentally specific groups, and psychopharmacology, and
- provider network rental (allows employees to have access to a ready-made network for a fee).

Key Program Components / Best Practices

Integration of physical and behavioral health

APS stresses the importance of increasing PCPs' awareness of behavioral problems that present with medical symptoms. APS works with its specialists to ensure they are communicating with primary care doctors at least when a patient is on medication, is being released after an inpatient stay for mental health or substance abuse, is diagnosed with a substance abuse problem that affects physical health, or is a potential danger to him- or herself or others.

In addition, APS emphasizes the importance of coordinating all members of the treatment team, including care managers, physicians, therapists, and facilities through its policies that direct the activities of each group in sharing treatment information about members. For example, APS asks every member to sign a release of information (ROI) form so that APS network

providers can immediately communicate with the PCP and receive a copy of the patient's most recent physical and laboratory data. The company also requires network facilities to request an ROI at admission so that the PCP can be notified of the admission and receive a copy of the treatment summary upon discharge. With prior consent, case managers also contact the patient's PCP when medical conditions present which may be complicated by medication or other treatment from a behavioral health provider.

APS pays particular attention to medication management issues. Behavioral health network providers are required to furnish the following information to members' PCPs:

- a list of all medication and dosage changes prescribed by a psychiatrist,
- indications of possible drug interactions or side effects,
- any potential medical or physical conditions that need further assessment,
- inpatient hospitalization with or without physical comorbidity,
- evidence of undiagnosed substance use,
- a treatment plan with a diagnosis, as well as length and time of treatment, and
- the expected therapeutic outcome for the behavioral health intervention.

Priority on Fostering Provider Relationships

The company prides itself on allowing providers the freedom to make the majority of decisions with minimal intervention from APS. This mutually rewarding arrangement allows APS to shift more resources from the day-to-day burdens of operations to quality control and oversight. APS staff also believes this relationship with providers distinguishes the company from other MBHOs that are

perceived by providers as micromanagers of physicians' clinical decision making.

APS has divided its provider network into three groups: *core*, *anchor*, and *prime*. The *core* providers are those who provide mental health outpatient services for the majority of members. This multidisciplinary group is a significant size and presence in the market, offers easy access to members, and in many cases has a proven clinical track record with APS. The providers are responsible for making treatment decisions and determining number of visits. APS's role is to monitor treatment retrospectively for quality and satisfaction, as well as to troubleshoot and facilitate paperwork. The *anchor* group functions similarly to the *core* group, but for inpatient services. The *prime* group encompasses the rest of the network.

APS has established a regional system (primarily focusing on the Midwest and Mid-Atlantic areas) through studying local markets and carefully selecting providers on behalf of its HMO clients. For example, if an HMO has developed a provider system supported by two local hospitals, APS will develop an infrastructure to support the client's existing system. The company has created a regional Provider Advisory Group, made up of a variety of primary and behavioral health care specialists, which is responsible for recommending quality providers in specific areas and is considered "the pulse of APS's local markets."

The majority of MBHOs contract with providers on a fee-for-service basis, but APS places some of its core group of mental health providers at full risk for services they provide. Some core group members receive reimbursement based on a single case-rate fee for *all* services associated with the care provided for a given diagnosis. The fee is the

same regardless of how much or how little time and effort the provider spends. If a provider no longer wants to participate in the program under case-rate reimbursement, he or she simply gives APS 30 days' notice.

Most of the company's well-established New York core provider groups have been receiving case rates since 1996. One of APS's goals in the next 2 years is to reimburse at least 50 percent of all outpatient providers (core groups) on a case-rate basis. Case-rate payment for chemical dependency services is also being contemplated.

APS considers itself an industry leader in developing technologies to make providers' lives "less challenging under managed care." APS reports that a key advantage of being a new player in the MBHO market is that from its inception the company had the opportunity to invest in sophisticated information systems. The company has designed and instituted a number of processes to help decrease provider time spent interfacing with the company. These initiatives include the following:

- *MemLink and AuthLink*: MemLink allows providers to check member eligibility for services 24 hours a day via telephone. Those seeking an initial authorization for routine care can transfer to AuthLink automatically for quick approvals, eliminating the need to complete paper forms.
- *Claims scanning and auto-adjudication*: APS's system can electronically convert handwritten claim forms into computer-ready information. The system receives information electronically from client customers through the Internet, or from tape, diskette, or telephone. Sixty-three percent of outpatient claims are auto-adjudicated.
- *CheckWrite*: This automated check writing service electronically facilitates the submission of check and explanation of payment

(EOP) distribution to providers, improving accuracy and delivery time. As a result, providers receive payment within 3 to 5 days of claim approval. CheckWrite processes 92 percent of provider checks.

- *Accessibility mapping:* This in-house technology allows staff to generate maps that show the availability of a network in the neighborhoods where members live and work.
- *APS Online:* This bulletin board system provides for online, direct communication of claims, membership, and contract information by selected providers using a standard modem connection.

The company has also created a case rate review form that captures all pertinent data from the Health Care Financing Administration 1500 form (i.e., DSM-IV diagnosis codes, common procedural terminology billing codes, taxpayer identification number, and provider signature) and eliminates the need for providers to generate paper claims.

Program Satisfaction and Quality Monitoring

Based on customer satisfaction surveys, 98 percent of employees are satisfied with APS's EAPs. The company also reports that its EAP utilization rates exceed the national average of 5 percent. In terms of behavioral health benefits, member survey responses suggest that 85 percent of members are satisfied with the services they are receiving.

APS believes that investing in quality assurance mechanisms and systems is critical and spends about \$2.5 million per year on such efforts. The company operates a centralized, automated information system that serves as a single warehouse to convert the data APS tracks into information that can be used to conduct historical comparisons, trend analysis, and ongoing quality improvement.

For example, the company's information system generates a daily report that identifies all patients who were triaged with urgent or emergency needs. APS then contacts each primary care provider to ensure an appointment was made; if not, staff call the patient at home to encourage him or her to seek additional care. In addition, the company's case rate review form helps track three key quality-of-care standards, as follows:

Measurements	Information Tracked
<i>Access measurement:</i> Patients' access to services as defined by the NCOA guidelines	<ul style="list-style-type: none"> • Emergent need • Urgent need • Routine need
<i>Episode of care measurement:</i> How long the patient receives treatment and the frequency of visits during course of treatment	<ul style="list-style-type: none"> • Duration of treatment • Average length of stay
<i>Outcome measurement:</i> Improvement or decline over the course of treatment	<ul style="list-style-type: none"> • Initial vs. end-of-treatment global assessment of function (GAF) score • All five axes completed according to DSM-IV standards

APS case managers also partner with network providers to develop treatment plans by offering suggestions and providing quality management oversight. The case managers have access to APS's medical directors for consultation and authorization reviews. The company also has developed utilization management guidelines, which staff and providers use to identify treatment options and plans.

In managing utilization, APS reviews treatment for each case retrospectively, except in cases where a member's condition deteriorates. The company monitors signals that indicate problems, such as 1) if a case rate review form indicates a decrease in the GAF score, 2) if a member requires a higher level of care, or 3) if a prescription does not match the diagnosis.

Performance Data

The Managed Behavioral Health Association has developed the Performance Measures for Managed Behavioral Health Care Programs (PERMS) to help address the issue of performance standards. PERMS is designed to create standardized report cards for overall MBHO performance by defining performance indicators followed by effective and efficient organizations and by collecting data to develop benchmarks for these measures. APS adheres to PERMS standards and provides full HEDIS reporting capabilities for NCQA accredited clients. The company also conducts ongoing evaluations of key performance standards in areas such as access, satisfaction, and service.

APS provides companies and HMOs with quarterly reports related to member and provider complaints, claims- and authorization-based data, standards appeals, and provider network activities. Monthly reports include abbreviated summaries of telephone response rates, claim turnaround percentage, complaint and complaint turnaround time, and critical incidence reports.

Among the benchmarks set by the company are

- 85 percent member satisfaction with services rendered,
- 95 percent of all telephone calls answered within three rings,
- emergency appointments provided within 1 hour, urgent appointments within 24 hours, and routine appointments within 7 days,
- 98 percent of clean claims paid within 30 days, and
- 24-hour response to all complaints and concerns.

Key Lessons Learned/Challenges Remaining

Lessons Learned

- Develop an expertise in local consumer and provider markets,
- Foster relationships with providers because their decisions, as well as level of satisfaction, have system-wide implications for patient care,
- Invest in data and technology to produce evidence of the company's good patient care management practices on improving health outcomes,
- Understand that HMOs and employers place an extremely high value on cost-effectiveness of behavioral health programs, provider satisfaction, and timely delivery of data on utilization, costs, and patient outcomes.

Challenges Remaining

- Expanding market share (particularly in the public sector), as well as building the informational system and organizational structure to support growth,
- Demonstrating to employers and HMOs the value of integrating behavioral health benefits with EAPs to maximize the value of benefits and to optimize patient outcomes,
- Recruiting providers that meet APS's quality criteria, as well as increasing the proportion of providers under case-rate reimbursement, and
- Maximizing information system capabilities, such as producing reports demonstrating decreases in employee absenteeism as a result of APS's services.

B. Harvard Pilgrim Health Care

NOTE: This study examined mental health services provided by Harvard Pilgrim Health Care before the company's recent financial hardships. Although Harvard Pilgrim currently faces the prospect of State receivership or sale to another MCO, the HMO's innovative mental health care benefits and delivery strategies nonetheless prove instructive. This case study reflects information gathered in late 1998 and 1999.

Company History / Profile

NOTE: This profile is based heavily on Stelovich (1996).

Founded in 1969 as Harvard Community Health Plan, Harvard Pilgrim Health Care (HPHC) is New England's largest nonprofit MCO. *U.S. News & World Report, Consumer Reports*, Sachs, and Kiplinger's HMO Score Card have recognized it as one of the finest HMOs in the country. *Newsweek* named it the nation's top HMO in 1998.

Serving more than 1.25 million members in Massachusetts, Rhode Island, New Hampshire, Vermont, and Maine, HPHC has nearly 20,000 physicians, including over 4,000 behavioral health clinicians, and 140 hospitals in its network. These clinicians have practices in all types of professional settings, including staff model health centers, multi-specialty medical groups, and independent practices. More than 8,000 employers offer HPHC to their employees. HPHC provides integrated physical and behavioral health benefits to many of its employer-purchasers.

Although it did not originally offer comprehensive mental health and substance abuse benefits, HPHC has a long history of progressive and integrated health care. In 1976, HPHC began to establish a comprehensive delivery system through its staff model

HMO. Each of HPHC's centers recruited psychiatrists, psychologists, psychiatric nurses, and licensed social workers to work collaboratively. In addition, HPHC favored short-term group psychotherapy over longer-term individual treatment modalities. The company informally extended benefit limits when additional outpatient support could offset hospitalizations, enabling the patient to receive care in the least restrictive setting and saving HPHC money.

In 1976, Massachusetts also passed legislation requiring insurance companies to cover up to \$500 or 20 visits annually for outpatient health services without regard to diagnosis (i.e., mental and physical health diagnoses were treated equally). This legislation specified the minimum amount of coverage and prohibited discrimination against certain chronic conditions. The State reinterpreted the 1976 law to favor wider exposure for managed care programs, effectively requiring unlimited inpatient care for acute psychiatric conditions.

Recognizing the limits of its staff model approach and facing increased cost pressures, HPHC expanded its size and structure and redesigned its mental health benefits. In a 1986 merger, HPHC joined with Multi-Group Health Plan and began providing services through capitated groups in its new Medical Groups Division. In 1987, HPHC initiated a Mental Health Redesign Project to determine how to expand a mental health benefit to include appropriate treatments for behavioral health problems while limiting financial risk.

The Redesign contained two components: 1) the Patient Assessment Tool, a protocol to simplify and standardize treatment, and 2) incentives to encourage wise use of psychotherapy. The new incentives realigned

patients' expectations of treatment length with what was financially and clinically reasonable while accommodating the needs of more severely ill clients. The project also adjusted levels of cost-sharing based on medical condition. During the redesign, HPHC developed its intensive outpatient programs.

A 1995 merger with Pilgrim Health Care led to the newly named Harvard Pilgrim but had few direct effects on mental health benefits. HPHC took further steps to improve mental health delivery in 1998 as it reorganized 14 Boston-area staff model health centers as Harvard Vanguard Medical Associates, a clinician-led, multispecialty group practice with 600,000 members and 35,000 providers. Strong relationships between practice areas and a collegial atmosphere among physicians characterize the Harvard Vanguard environment. Fostering integration of care, mental and physical health clinicians share office space. All 14 Harvard Vanguard sites have a range of medical personnel, including emergency room staff, on-site. Harvard Vanguard staff are salaried with incentives connected to patient satisfaction and the financial performance of the entire practice instead of to utilization.

HPHC's delivery system covers three regions: Massachusetts, Southern New England, and Northern New England. In Massachusetts, HPHC operates as a network model of independent practice associations (IPAs) and Harvard Vanguard Medical Associates. The Southern New England Region offers a combination of a network and staff model. Here, HPHC hopes to manage complex cases more tightly in the staff model while leaving less-intensive cases in the network. Northern New England members use different provider networks.

Mental Health Benefits

Harvard Pilgrim offers four health care plan options: the HMO, POS, PPO, and First Seniority, a health care plan for Medicare beneficiaries. This case study will focus on the most common employer-purchased plans: the HMO and the PPO.

HPHC offers a full spectrum of services and programs based on medical necessity. Outpatient services include therapy (individual, group, couple, or family), screening for depression and substance abuse in primary care, and pharmacological management in behavioral health and primary care. The company has developed multiple mechanisms to provide specialized and intermediate care, such as diagnosis-specific group therapy, specialized counseling, continuing care groups for the chronically mentally ill, dialectical behavioral training therapy, self-help groups, neuropsychological testing, and adolescent after-school programs. In addition to acute inpatient hospitalization, HPHC offers members a variety of alternatives to hospitalization, including crisis intervention, observation beds, day treatment, outpatient detoxification, home visits, and an intensive treatment program. Limitations vary depending on the particular plan. All members can access services by contacting the Mental Health Access Center via a toll-free telephone number. In an emergency, members may seek an evaluation at an emergency facility without a referral.

The Mental Health Executive Committee (MHEC) oversees mental health benefit design in all HPHC regions. The MHEC has overarching responsibility for the development of corporate plans, policies, and practices regarding mental health issues. The committee works closely with clinical and administrative leadership in the primary care and medical/surgical specialties. The MHEC

encourages a climate of continuous quality improvement in the clinical practices and seeks the most effective forms of assessment, treatment, and prevention so best practices can transfer across sites and regions.

HPHC also offers an extensive worksite wellness program at approximately 660 client company locations. HPHC's Center for Employer Health Programs works with employers to become familiar with the worksite, the employees, and the working environment.

Key Program Components / Best Practices

HPHC has implemented a variety of innovative programs to improve member service; these programs focus on screening and detection, inpatient and crisis services, research, and quality assurance.

Screening and detection (IPA-style medical groups):

In 1997, Harvard Pilgrim instituted the Early Detection of Depression Pilot study at one of its larger, IPA-style medical groups. This pilot aimed to develop assessment and treatment guidelines for PCPs to screen patients for depression. The study team developed a simple, easy-to-use screening form and offered training to providers. To overcome initial practitioner resistance to using HPHC's depression screening instrument on its enrollees, HPHC paid providers to screen *all* patients, not just HPHC members. HPHC recognizes that quality and consistency are more difficult to achieve in an IPA model, where providers serve patients from several plans, each with varying reporting requirements. The program has been successful in a variety of ways. First, HPHC detection rates have approached what the Agency for Health Care Policy and Research reports as the actual prevalence of depression. Further, most

of these patients are willing to pursue treatment. Finally, physicians are complying with the study, even though they no longer receive bonuses for screening; they now believe in the need for this service.

Recognizing the difficulty in convincing network doctors to use new technology, HPHC management has met with the medical directors of other major health plans to coordinate services and develop standards for communication and reporting. The group hopes to standardize mental health detection and treatment procedures, thereby reducing the burden on individual doctors and increasing willingness to comply.

Inpatient and alternative services:

- Although HPHC does not enroll enough children to warrant owning a children's hospital, it has a sufficient base to influence practices and implement innovative programs at the two Boston area children's hospitals.
- HPHC created the nation's first HMO-owned and -operated psychiatric day hospital. It now includes a day and evening substance abuse program and aftercare groups for clients.
- In an effort to create a more comfortable and less expensive alternative to 24-hour hospital-based care, HPHC helped a vendor develop an adult psychiatric hospital in a residential setting. The estate-like environment provides intensive services to patients who do not require a locked facility, restraints, or complex medical support.
- At a local hospital that it does not own, HPHC built a crisis unit providing a small number of holding beds and intensive psychotherapy and drug therapy. HPHC encourages the hospital to use the unit by reimbursing services at the same rate as a

day of inpatient care. The holding beds have a diversion rate of 50–60 percent. The unit reduces the length of stay for inpatient hospitalizations and reduces HPHC’s exposure to higher inpatient costs.

- HPHC operates the First Seniority Team, a unit that travels to nursing homes to treat the elderly. Psychiatrists always travel with the team to diagnose and treat mental illness.
- Harvard Vanguard health centers include a Strike Team, a team of case managers that helps reduce inpatient admissions among its high-utilization patients. The case managers, bachelor’s-level social workers, conduct outreach and help patients with compliance issues such as maintaining medication regimens and keeping appointments. The Strike Team works with the appropriate clinician to help with patient treatment. The program is popular among patients and has reduced the number of admissions among the high-utilization population.

Research:

- The Harvard Pilgrim Health Care Foundation funds unique teaching, research, and community service programs. Foundation-supported programs include the Department of Ambulatory Care and Prevention, a partnership of HPHC and the Harvard Medical School; research on prevention and other health practices; AIDS awareness and education for teens; and violence prevention.

Program Satisfaction and Quality Monitoring

HPHC monitors program satisfaction through the Consumer Assessment of Health Plans Survey (CAHPS) 2.0H instrument. This survey, required by the NCQA for plan accreditation,

measures member satisfaction over a wide range of services to assess how well the health plan meets member expectations. Table 17 summarizes several key survey results.

In addition to examining consumer satisfaction, HPHC examines independent data to evaluate the quality of its providers. For behavioral health providers, HPHC uses four main approaches:

1. *System-wide examination of outcomes data.* HPHC compares the suicide rate of its members to the overall rates in Massachusetts; the suicide rate in the Commonwealth is currently about twice the suicide rate of HPHC members. In the event of a suicide, a committee investigates the problems in each case’s treatment and evaluates whether improvements can be made at the provider or system level. In addition, the committee tries to discern any relevant trends. The process is important to ensure quality; however, it has met with some resistance from network doctors.
2. *Program/provider-specific performance.* HPHC’s behavioral health program uses generic screens, such as the unexpected death of a patient, patient elopement, and medication errors, to monitor provider performance. HPHC regularly reviews inpatient records for sentinel events, which are recognized as indicators of potential quality-of-care problems. The organization requires each region to establish procedures for implementing screens on inpatient records and to review positive findings appropriately.
3. *Investigation of consumer complaints.* HPHC carefully monitors member complaints about mental health clinicians. Many times, a complaint results in professional coaching for the involved provider by a colleague. The Credentialing Commit-

Table 17: 1999 NCQA/CAHPS 2.0H Member Satisfaction Survey Results		
Satisfaction Area	Score	Scale
Overall satisfaction	89%	Completely / Very / Somewhat Satisfied
Recommend	92%	Definitely / Probably Would Recommend
Intent to switch	93%	Definitely / Probably Not Switch
How much of a problem, if any, were delays in health care while you waited for approval from your health plan?	91%	Not a problem
When you called during regular business hours, how often did you get the help or advice you needed?	88%	Usually / Always
When you needed care right away for an illness or injury, how often did you get the help or advice you needed?	91%	Usually / Always
How often did office staff at doctor's office or clinic treat you with courtesy and respect?	97%	Usually / Always
How often were office staff at doctor's office or clinic as helpful as you thought they should be?	92%	Usually / Always
How often did doctors or other health providers listen carefully to you?	93%	Usually / Always
How often did doctors or other health providers explain things in a way that you could understand?	94%	Usually / Always
How often did doctors or other health providers show respect for what you had to say?	95%	Usually / Always

Source: HEDIS 1999 Report for Harvard Pilgrim Health Care.

tee reviews the performance of any provider who receives more than three complaints in a single year. The Patient Care and Assessment Committee reviews more serious complaints.

4. *Medical audits.* As part of the recredentialing process, HPHC asks all mental health providers to submit five medical records for peer review of appropriate case documentation. Clinicians review the records against Harvard Pilgrim's mental health record standards and notify the individual provider of the review results.

Performance Data

HPHC maintains a detailed tracking program to monitor its performance data. As described in its 1999 HEDIS Report, HPHC regularly tracks several key cost and utiliza-

tion indicators of its mental health, substance abuse, and prescription drug services, including

- *Followup after hospitalization for mental illness:* For patients recently released from inpatient programs, outpatient visits with mental health practitioners can reduce recidivism and facilitate the transition to the home or work environments. HPHC tracks the percentage of hospitalized mental health patients who were continuously enrolled for 30 days after discharge and who received some form of outpatient treatment (ambulatory care or day/night treatment). Sixty-eight percent of these patients met these criteria and sought outpatient care within 7 days of discharge; 86 percent sought such treatment within 30 days of discharge.

- *Antidepressant medication management:* To address the success of pharmacological management of depression, HPHC monitors three performance indicators measuring the percentage of patients with new episodes of depression who were treated with antidepressant medication and who meet specified treatment criteria. Almost 30 percent received at least three outpatient visits during the 84-day acute treatment phase; this measure, called the Optimal Practitioner Contacts for Medication Management, assesses the level of clinical management of new adult patients. Sixty-five percent met the standards for the effective acute phase treatment by remaining on an antidepressant medication during this entire phase. The effective continuation phase treatment measure, which assesses the effectiveness of clinical management in ensuring compliance, found that almost 50 percent remained on an antidepressant medication for the 6-month continuation phase.
- *Mental health, substance abuse, and pharmacy utilization:* HPHC tracks, by age and sex, the frequency and level of behavioral health care its members receive. Over 9 percent of members access mental health services; most care is ambulatory, with less than 0.33 percent of members receiving inpatient or residential services. Only 0.53 percent of members access substance abuse services; over 85 percent of this care occurs in an outpatient setting. HPHC also monitors the cost and utilization of prescription drugs. An average member receives 8.61 prescriptions every year and spends \$32.01 per month on all (physical and mental health) prescriptions.

Challenges Remaining

Since its inception, HPHC has significantly changed the way it approaches behavioral health treatment. However, it faces continual pressures to reduce costs as well as a challenging, competitive, and maturing marketplace. HPHC's reputation for quality remains, but in today's market many employers choose insurance carriers by cost. HPHC must convince employers of the value of quality services and of supporting health plans that can provide comprehensive services for employees. Specifically, HPHC must confront three main challenges:

- *Market pressure:* The increasing pressure to contain costs may jeopardize HPHC's ability to provide appropriate and accessible behavioral health services. This challenge is most apparent with Harvard Vanguard, whose reputation is based on offering innovative and integrated services. However, the trend in managed care appears to be shifting away from staff model HMOs, which offer only limited geographic access and carry higher per-member monthly rates. Nonetheless, Harvard Vanguard has been at the forefront of many of HPHC's innovations and provides a strong model to ensure the availability of comprehensive integrated behavioral health services. For HPHC, participating and receiving research grants has ensured continued progress. Administration and staff believe the continued supply of Federal and foundation demonstration dollars is an absolute necessity to improve practice and to test new ideas.
- *Managed care market consolidation:* Extensive mergers and acquisitions have changed the business environment from a

marketplace of regional or local companies to one dominated by national and multinational corporations. These larger companies want to reduce the number and variety of health plans they contract with, making national insurers an attractive option. Regional HMOs like HPHC face competitive disadvantages. After going national, at least one of HPHC's customers sought a national vendor.

- *Review of contracting approach:* In the long run, HPHC must look to more lucrative business practices that complement its philosophy and strengths. Its worksite wellness programs may be one avenue that allows HPHC to continue providing comprehensive benefits. The carve-out business may be another route to financial stability, but this option does require some compromise of HPHC's traditional methods of integrated service delivery. HPHC must address the trend in the market to unbundle services and contract them out on a carve-out basis. HPHC does not currently work as a carve-out for other HMOs but is considering the possibility. HPHC recently contracted with a marketing consultant to develop a feasibility plan.

C. HealthPartners

Company History / Profile

HealthPartners (HP) is a nonprofit, consumer-governed HMO and insurer based in Minneapolis, Minnesota. The organization consists of health care organizations, plans, and a hospital system that provides health care services, insurance, and HMO coverage to 800,000 members. HP offers its products to individuals and employers and supports the coverage options for 29 of Minnesota's largest employers. Dedicated to serving its

members, HealthPartners is virtually a member-run organization, as 80 percent of its board of directors are consumers elected by the members.

HP, in its current configuration, is the product of a series of mergers and affiliations, the largest of which was the 1992 merger of Group Health, a Minneapolis-based staff model HMO established in 1957, and MedCenters Health Plan, a network model HMO founded in 1972. In 1993, an affiliation with Regions Hospital and Ramsey Clinic System broadened the company's network of clinics and hospitals by adding a major teaching hospital and nearly 50 medical and dental centers throughout the Twin Cities and western Wisconsin. These facilities provide a full range of services, including behavioral health care.

In 1996, the plan's staff model, clinic, and hospital physicians (550 physicians and 23 clinics) combined to form the HealthPartners Medical Group. The Medical Group consists of four divisions: primary care, medical subspecialties, surgical subspecialties, and behavioral medicine. HP currently operates both the staff model Medical Group and the network model MedCenters Health Plan. HP's network includes 45 medical groups at more than 220 sites across Minnesota.

A large degree of horizontal and vertical integration of health care organizations and a strong regulatory environment characterize HP's Twin Cities market. The area is also home to one of the most active and well-known employer purchasing coalitions, the Buyers' Health Care Action Group, which purchases health care services on behalf of more than 15 percent of the metropolitan area's covered lives. It thus enjoys enormous leverage over all aspects of the health care arena in the Twin Cities. HealthPartners and

its component entities have experienced the types of market pressures that other HMOs, health systems, and providers across the country are now facing.

Mental Health Benefits

Group Health, one of HP's predecessors, has a longstanding commitment to integrating physical and behavioral health services; over the past 15 years, it has worked to improve early identification and treatment of mental health conditions in the primary care setting. While the recent merger and affiliation activity has made it more difficult to provide the same approach to and level of integration across the entire provider network, HP is committed to its approach and is working to further its adoption.

HP offers standard plans to individuals and small employers plus a menu of services with other options for larger companies. State law in Minnesota requires that fully insured HMO products impose no limitations on mental health inpatient days. Outpatient limits and cost-sharing requirements for mental and physical health care vary by plan. HP's entire system offers direct access for behavioral health care; it requires no referrals.

Roughly one-third of HP's membership (about 240,000 individuals) enrolls with the Medical Group and two-thirds with the Med-Centers Health Plan. This study will focus on the staff model Medical Group, the area in which HP has implemented the widest variety of innovative behavioral health programs and services. In the Medical Group, HP has been able to test its approaches across a broad spectrum of conditions and providers. Moreover, the staff model and clinic-focused delivery system allow for greater innovation at the service delivery level by co-locating PCPs, specialists, and mental health practitioners.

These providers work collaboratively in the primary care settings as the "front end" of the mental health delivery system.

Key Program Components / Best Practices

Health Promotion and Risk Reduction

The Partners for Better Health program, a series of unique, highly proactive, company-wide initiatives designed to reduce the incidence of disease and health risks, sets specific, measurable goals for health improvement. The program includes a number of member services and programs:

- The Partners for Better Health Phone Line allows members to talk directly with a health educator or dietitian to develop personalized health improvement action plans. Members can also complete the Partners for Better Health Survey, a confidential health risk assessment, over the telephone. Members receive confidential feedback with recommendations for individual lifestyle and health improvements. With permission, HP also sends the risk data results to members' health care providers.
- The Partners for Better Health Employer Initiative (PBHEI), launched in 1995, is a program specifically designed to improve the health of employees and dependents who carry HP health insurance. PBHEI demonstrates an approach that is integrated, focused, population-based, synergistic, systematic, and goal-driven, with interventions that help people actively change their lifestyles and are effective in preventing relapses.

PBHEI identified the most prevalent preventable conditions among members and dependents for the companies it serves. Mental health problems ranked among the top

five preventable conditions. In addition, the study found depression to be one of the top five reasons patients make visits to their primary care clinic.

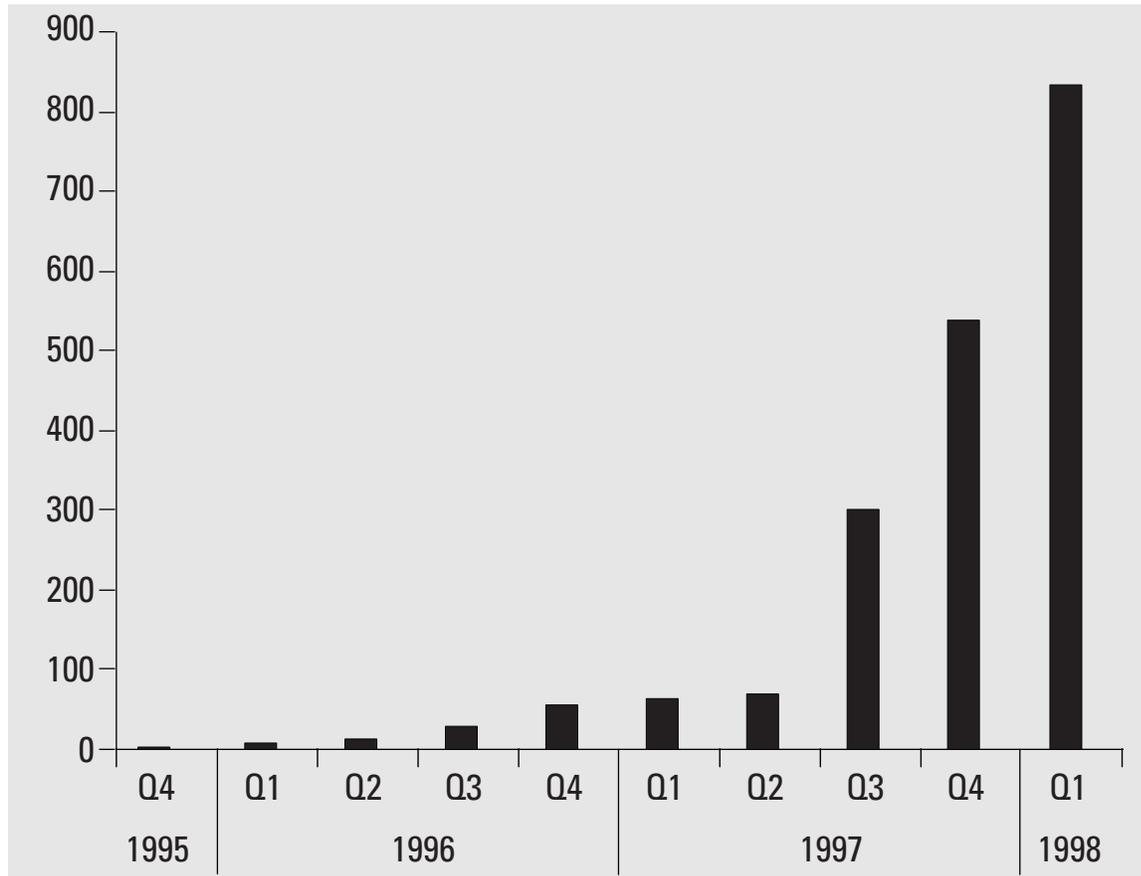
As seen in Figure 1, enrollment in PBHEI grew rapidly during 1997 and 1998.

- HealthPartners EAP is a free, confidential, 24-hour resource integrated into HP's contracts with employers. The program helps employees resolve personal and relationship issues, as well as substance abuse, legal, and financial problems in an attempt to reduce stress and increase productivity.
- HP operates a Center for Health Promotion, which serves as a testing ground for initiatives before they are fully implemented. The center documents feedback

on the initiatives provided by patients who call HP's help lines, enters it into their medical charts, and tracks it through an information system.

- HP investigates systematizing primary care for depression through an evaluation project, called the Diamond Project, which aims to demonstrate that primary care clinics can develop systems to more consistently manage and follow up with depressed patients and to describe and evaluate the change process used to do this, the new care process, and its effects. The project has found that low-end management (such as 5-minute telephone calls with patients) can have as much of an impact as medication on patients with depression.

Figure 1: PBHEI Employer Group Enrollment Pattern, Cumulative Number of Groups Enrolled by Quarter



Integration

Whereas many health plans consider a good referral network to be an integration of mental health services and primary care, HP takes integration a step further—patients can see psychiatrists and PCPs simultaneously in a primary care setting. HP’s sophisticated case management system coordinates these services.

Since 1991, HP’s Medical Group has focused on integration of physical and mental health services. This priority and philosophy have transformed HP’s practice. HP has developed guiding principles for the role of mental health in specialty care. It hopes to rejuvenate family practices by integrating psychiatric and primary care in particularly difficult cases and eventually delivering 70 percent of mental

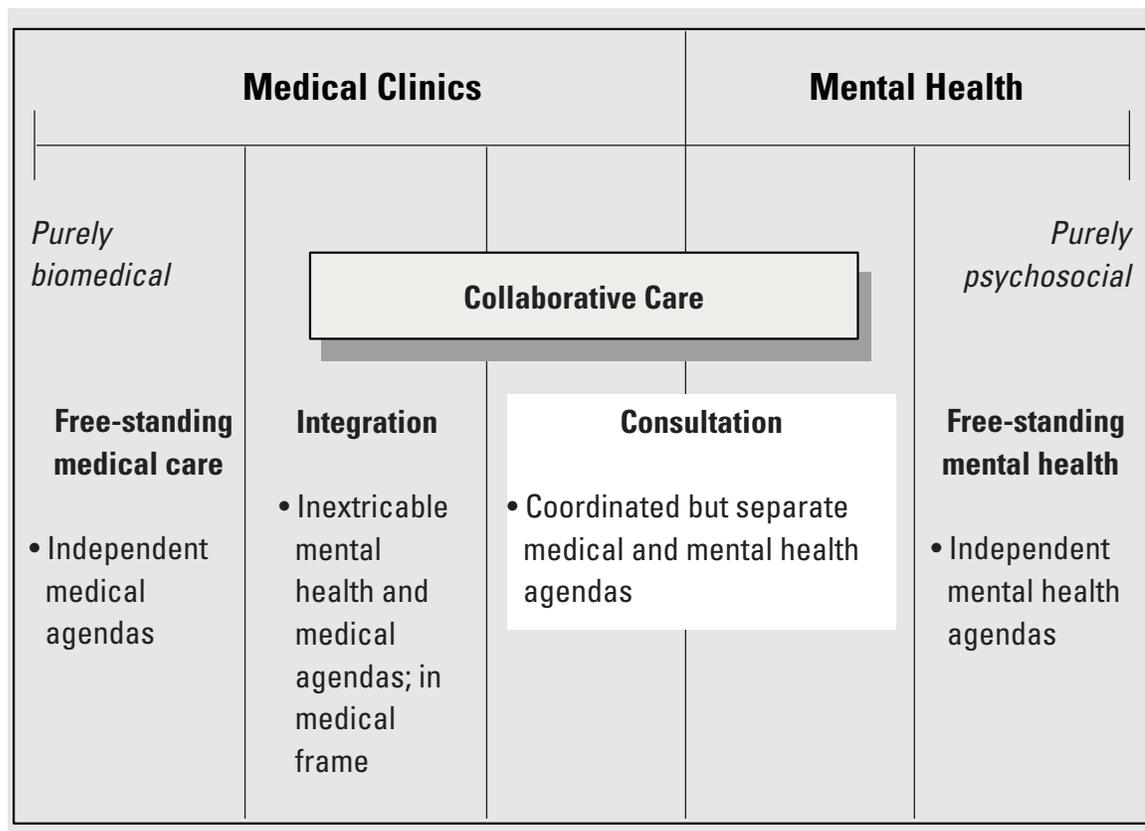
health services in primary care settings. Currently, only 25 percent of mental health services occur in a primary care setting.

According to HP’s Primary Care 1996 Annual Plan, the principles of primary care are

- 1) *comprehensiveness*: “provision or coordination of all healthcare needs in a biopsychosocial model,”
- 2) *advocacy*: “physician or team helps patients and families find their way within the care system,” and
- 3) *population and individual patient focus*: “providing care for an appropriately sized panel of patients.”

Leaders at HP have conceived a continuum of biopsychosocial care depicting the range of

Figure 2: The Biopsychosocial Care Continuum: A four-sector model



Source: C. J. Peek & R. L. Heinrich, *Syllabus: Elements for collaborative care and organizational change* (Minneapolis, MN: HealthPartners, 1998).

clinical problems. They posit that the majority of cases require a blend of biomedical and psychosocial treatment.

HP's integrated care and preventive services have produced numerous benefits. From a physician's perspective, integration has reduced family practice "burn-out." Many PCPs have several very difficult patients who do not respect the mores and boundaries of the physician's practice, which can lead doctors to become frustrated with their practice.

For example, HP staff recounted a story in which a family practitioner was treating a woman who complained of persistent migraine headaches and repeatedly demanded methadone treatment. She was a difficult patient with a number of physical and behavioral health problems and monopolized the physician's time. By calling in a psychiatrist colleague, the physician was able to diffuse the situation. Collaboratively the doctors created a treatment plan to address all of her needs. HP believes this model, in which psychiatrists are available to treat difficult or mentally ill patients, can help both the patient and the family physician. HP's case management system facilitates communication between primary care and mental health professionals.

Because of its geographic expansion into more rural areas that lack mental health practitioners, HP has taken an increasingly important role in supporting PCPs who must provide much of the mental health care services in a region. These physicians are particularly likely to burn out, given the demands on them as the only, or one of the few, health care providers in the area. In these situations, HP has had success in sending senior mental health professionals to work with these rural providers. The mental health specialists provide physicians with the clinical and collegial support necessary to treat patients appropri-

ately and to set boundaries for themselves as sole health care providers.

Clients have enjoyed benefits in this integrated approach as well. HP has found the market enthusiastically in support of the PBHEI. Moreover, HP has found that some PBHEI companies have enjoyed reduced insurance rate increases over the course of 2 years. The EAP provides another outlet for behavioral health care integrated with the physical health program. Through the EAP, employers can gain a better understanding of the problems in their employee workforce. Employers are also particularly attracted to an advice line specifically for supervisors to call about employee issues.

Program Satisfaction and Quality Monitoring

HealthPartners monitors program satisfaction through a survey developed by the NCQA to be incorporated into the HEDIS. This instrument measures member satisfaction over a wide range of criteria including quality, cost, and accessibility of services. Table 18 summarizes the 1998 survey's key results.

Performance Data

In addition to satisfaction with its services, HealthPartners monitors utilization, cost, and a variety of other factors in order to improve the care it provides. In terms of mental health, HealthPartners regularly tracks hospital readmission for psychiatric patients. Studies have shown that, for hospitalized behavioral health patients, appropriate management of care immediately after release reduces readmission rates. As a result, HealthPartners attempts to provide comprehensive followup care and schedules the first outpatient visit before the patient leaves the hospital. Data from 1997 suggest that 69 percent of members¹⁰ hospitalized for treat-

¹⁰In 1997, the national average for this measure was 67 percent.

Table 18: 1998 NCQA/HEDIS 3.0 Member Satisfaction Survey Results		
Satisfaction Area	Score	Scale
Overall Satisfaction		
Overall, how satisfied are you with HealthPartners?	86%	Completely / Very / Somewhat Satisfied
Would you recommend HealthPartners to family and friends?	88%	Definitely / Probably Yes
Do you intend to switch to a different health plan when you next have an opportunity?	90%	Definitely / Probably Not
Have you called or written HealthPartners with a complaint or problem in the past 12 months?	11%	Yes
Quality of Services		
Ease of making appointments for medical care by phone.	82%	Excellent / Very Good / Good
Length of time between appointment and visit.	64%	Excellent / Very Good / Good
Thoroughness of treatment you received.	85%	Excellent / Very Good / Good
Attention given to what you had to say.	87%	Excellent / Very Good / Good
Number of doctors you had to choose from.	77%	Excellent / Very Good / Good
Ease of choosing a personal physician.	77%	Excellent / Very Good / Good
Amount of time you had with doctors and staff during visit.	79%	Excellent / Very Good / Good
Satisfaction Area		
How much you were helped by the care you received.	84%	Excellent / Very Good / Good
Overall quality of care and services.	86%	Excellent / Very Good / Good
Cost of Services		
Types of services the plan covers.	83%	Excellent / Very Good / Good
Availability of information regarding eligibility, covered services, or administrative issues.	79%	Excellent / Very Good / Good
Availability of information regarding cost of care.	72%	Excellent / Very Good / Good
Length of time completing claim forms or other paperwork.	88%	Excellent / Very Good / Good
The cost you paid to belong to HealthPartners.	68%	Excellent / Very Good / Good
Amount you had to pay out-of-pocket.	70%	Excellent / Very Good / Good
Accessibility of Services		
Delays in care while waiting for plan approval.	86%	Not a problem
Difficulty in receiving care you and your doctor believed was necessary.	89%	Not a problem
Not being able to get a referral to a specialist that you wanted to see.	85%	Not a problem
Waiting Time (between appointment and visit to provider)		
Routine care.	57%	Same day to 14 days later
Minor illness or injury.	88%	Same day to 3 days later
Chronic or ongoing condition.	83%	Same day to 14 days later
Urgent care.	94%	Same day

Source: HEDIS 1998 Report for HealthPartners

ment for various mental health disorders were continuously enrolled for 30 days after discharge and were seen either on an ambulatory basis or in day/night treatment with a mental health provider within 30 days of hospital discharge.

Challenges Remaining

Particularly with the move toward a greater reliance on contracted network providers, HealthPartners continues to develop new risk models and approaches to behavioral health care delivery. Several new approaches are being tested, such as

- including pharmacy risk (including mental health pharmaceuticals) in physical health capitation rates;
- allowing primary care clinics to select the behavioral health “partners” with whom they will share risk and whom they will use as their principal referral network;
- using stop-loss types of arrangements for certain types of high-cost, low-incidence cases (e.g., bipolar, obsessive-compulsive, eating disorders);
- developing behavioral health centers of excellence to which the entire provider network will refer appropriate types of cases; and
- limiting primary care risk-sharing for behavioral health (e.g., 20 percent of behavioral health risk within the primary care capitation rate).

HP is also testing new approaches to chronic care delivery. One recent initiative involves the use of telephone followup. HP nurses and care managers make a total of six telephone calls during the first 6 months following an episode—initially at 2-week intervals and phasing into one call every 2 months. HP staff are evaluating the success

of this approach and believe that it contributes more to positive care outcomes than other, more traditional, chronic care (e.g., medications and other types of followup).

As with HPHC, the primary stressors for HP are carve-outs and large mergers producing nationwide companies. HP’s dedication to integrated services is not attractive to a number of employers who feel it is beneficial and economically advantageous to use carve-outs for mental health and substance abuse treatment services. In addition, while HP has a large presence in Minnesota and neighboring States, companies with offices nationwide tend to prefer leveraging their purchasing power and simplifying health benefit administration through contracts with one or two vendors for all of their employees.

HP has had some success in attracting clients with its unique programs. In one case, a group of county employees left HP in favor of a large, national carve-out. Eventually, the group was dissatisfied with the kinds of services the new organization provided and returned to HP. HP’s experience and this type of response by an employer may be somewhat unique to the Twin Cities. Minnesota’s health care delivery model involves a long-standing reliance on primary care and multidisciplinary health care delivery (e.g., large multispecialty group practice clinics). Furthermore, the area’s purchasers play an active role in shaping the health system; the active buyer coalition also brings with it additional infrastructure requirements to meet employers’ demands for quality assurance, consumer protection, and outcomes data. Recognizing these regional characteristics and meeting such expectations are critical components to HP’s approach and success as a regional player.

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