Substance Abuse Services for Multiemployer Fund Participants
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Introduction

Substance abuse among workers, both in the workplace and at home, has become an increasing concern. The total economic cost of alcohol and substance abuse was estimated to be $276.3 billion in 1995.¹ The growth rate for medical costs related to substance abuse and mental health problems (which are frequently interconnected) is more than double the growth rate for the cost of general medical and surgical care.²

In addition to health plan costs, indirect costs include disability and workers’ compensation costs, reduced productivity, more absences, reduction in the quality of work, increased turnover, more accidents and theft in the workplace. As a result, some plan sponsors, seeking to minimize the negative effects of substance abuse, have turned to prevention and early intervention activities, and the use of employee assistance programs (EAPs, also referred to as member assistance programs, or MAPs), to help ensure participants receive the most appropriate assistance in a timely manner.

Numerous articles and studies have examined drug testing and EAPs in the corporate arena. The prevalence, or availability, of these services and activities is less well documented among multiemployer funds. Part of the reason may be the organizational structure makes it possible for fund participants to receive services from multiple sources: fund, union, individual employers or employer associations. (See Appendix A.) There may or may not be one person in a position to describe the whole range of services available through each organization. And, since individual employers may offer different programs, the services or activities affecting some participants may differ from those of others.

EAPs, and prevention and early intervention programs, are particularly important to multiemployer funds. The hazardous nature of the construction and transportation industries, within which a large number of multiemployer fund participants work, makes substance abuse prevention and intervention a major component of workplace safety.


Survey Highlights

FEBP mailed a survey to salaried administrators of 722 multiemployer health funds. Responses were received from 185 funds (a 26% response rate). These 185 multiemployer health funds provide benefits to nearly 800,000 participants.

Salaried administrators were chosen as the subject of the survey following extensive interviews with salaried administrators, third-party administrators (TPAs), labor and management trustees, and consultants. Although some multiemployer funds are administered by TPAs, TPAs are not included in this study because available TPA contacts are individuals who may or may not directly provide administrative services for a fund, or in some cases provide administrative services for multiple funds.

Participants of multiemployer health funds have access to, or are the subject of, substance abuse prevention, early intervention and treatment activities from multiple sources. These sources include trust funds, unions and employers or employer associations. (See Appendix A.)

The percent of salaried administrators indicating health fund participants have access to, or are affected by, selected early intervention and prevention activities are shown below in Highlights at a Glance.

Of administrators indicating fund participants have access to an EAP, 73% reported EAPs were sponsored by the trust fund, 17% indicated a union sponsored the services and 19% indicated some individual employers or an employer association sponsored EAPs for participants. Eleven percent indicated participants have access to EAPs through more than one of these organizations.

In 1998, the average annual cost of EAP services per participant (for those funds sponsoring EAPs) was $29. The median annual cost per participant was $25.

Of those administrators whose fund participants have access to an EAP, 66% believed the EAP has reduced health plan costs, 49% believed it reduced disability costs, 41% believed it reduced workers’ compensation costs and 57% believed it reduced turnover and job loss.

While it is difficult to directly compare rates of utilization, the average EAP utilization rate in 1998 (users as a percent of eligible participants) was 10%. The average utilization rate of EAPs for drug and alcohol problems was 4%.

Highlights at a Glance

- **Counseling and referral for drug and alcohol problems**
  - By telephone ........................................ 55%
  - In-person ........................................... 48%

- **Educational activities**
  - Mailings/newsletter ............................... 29%
  - Worksite posters ................................. 24%
  - Workshops/presentations ...................... 21%

- **Wellness and health promotion activities**
  - Health fairs ....................................... 23%
  - Health risk assessments ....................... 20%
  - Stress management .............................. 11%
  - Peer interventions ............................... 10%

- **Training of supervisors to recognize signs of substance abuse** ........................................ 32%

- **EAP** .................................................. 46%
Prevention and Intervention Services

Both the types and sources of substance abuse-related services available to multiemployer health fund participants vary. Early intervention and assistance with substance abuse problems encompass activities that include counseling and referrals for treatment, evaluations, educational and awareness building efforts, and training supervisors to identify substance abusers. Services to participants may be provided through EAPs or MAPs sponsored by a multiemployer health fund or through formal and informal services and EAPs offered by unions, employers and employer associations affiliated with multiemployer funds.

Counseling and Referrals

Counseling and referral to professional services is often a central feature of substance abuse prevention and assistance efforts. Counseling and referral services can be offered through an EAP or through less formal means. Figure 1 shows the percent of funds whose participants have access to counseling and referral services for substance abuse and alcohol problems, whether by telephone or through in-person meetings.

A larger percent of salaried administrators whose fund participants have access to EAPs indicated availability of counseling and referral services than salaried administrators whose fund participants do not have access to EAPs, as shown in Figure 2.

Some experts discount the value of some telephone services that consist largely of information-only calls and referrals without an assessment. Traditional EAPs and some less formal services, however, try to use the telephone service to engage participants in a thorough assessment prior to referral. Differentiating between these two types of telephone activities can be difficult.

Educational Activities

Other activities designed specifically to aid in substance abuse prevention and early intervention range from workshops and presentations to worksite posters and health fairs. These activities play an important role in raising awareness about substance abuse, other issues related to substance abuse, and services available to persons with substance abuse problems. In fact, a strong program of awareness activities may lead to more utilization of available services, and greater use of services before problems become severe and more difficult to manage. Figure 3 on page 4 shows the prevalence of substance abuse educational activities reported by salaried administrators for all funds.

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As with counseling and referral services, substance abuse educational activities may take place through informal means or as a service provided through an EAP. Educational activities are much more likely to occur when an EAP is available, as shown in Figure 4.

**Wellness and Health Promotion**

Depending on their content, wellness and health promotion activities may have some effect in preventing substance abuse, and in some instances, may also serve as early intervention. According to administrators, the most frequent activities available to participants are health fairs and health risk assessments, with some access to programs in stress management, peer intervention and parenting programs, as shown in Figure 5.

Survey responses show participants with access to EAPs are more likely to have access to wellness and health promotion activities compared with participants without access to EAPs, as shown in Figure 6. However, whether these activities are an integrated part of EAP services or an additional service available to participants outside the EAP may vary by fund.

**Supervisor Training**

Training supervisory personnel to recognize possible signs of substance abuse among employees is another important element of a prevention and early intervention strategy. Administrators were asked whether fund, union or employer substance abuse activities included supervisor training. Fifty-nine administrators (32%) indicated training is included in the activities of at least one source. Training is more likely to
take place if an EAP exists, as shown in Figure 7 on page 6. For a variety of reasons, the indication by a fund administrator that supervisor training occurs from one source or another (fund, union, employer or employer association) does not necessarily indicate that all persons in position of supervising fund participants have received training.

**Drug Testing**

Drug testing is the most direct strategy for substance abuse prevention and early intervention. Depending on the reason for testing and the range of substances involved, testing will vary. Testing for drugs can be conducted as a preemployment screening device and/or on a random basis covering all or a sample of employees with various frequencies. Drug testing can also be conducted for cause in response to a behavior problem or suspicion, or an accident, or as part of follow-up monitoring of a person who has previously been found abusing illegal substances.

Drug testing and specific follow-up activities are required by federal regulation for workers in some industries. For example, the federal Department of Transportation requires drug testing programs for civilian employees in safety-sensitive transportation positions, including positions in industries such as aviation, railroads, mass transportation, interstate bus and trucking, and maritime. Follow-up assessments must be provided for individuals testing positive.

Figure 8, on page 6, suggests drug testing is more likely to be conducted by employers and employer associations than unions or trust funds. Since

**Figure 5**

**Figure 6**

**Figure 8**
administrators cannot be expected to be aware of the drug testing practices of all employers and unions participating in the multi-employer fund, the amount of testing reported by administrators may not reflect the full extent of testing that actually takes place.

**Employee Assistance Programs**

*Access to EAPs*

Of the 185 administrators responding to the survey, 85 (46%) indicated their fund participants have access to formal EAP services through at least one of three sources. Among the 85 administrators whose fund participants have access to an EAP, nine (11%) indicated fund participants had access through more than one source. One indicated participants had access through all three sources: trust fund, union and employer or employer association. Figure 9 shows the sources of EAP services available to fund participants.

It is possible unions and union representatives are more active in the provision of EAP services to members than Figure 9 suggests. Some administrators may not be in position to be aware of all union EAP-related activities that affect fund participants. In addition, some unions negotiate for the EAP services that the multiemployer funds provide.

The true extent to which EAP services may be available to fund participants through employers and employer associations may not be reflected in Figure 9. Because funds include multiple contributing employers, fund administrators may not be fully aware of individual programs and services offered by each employer. Or, an administrator may be aware of services that may be available to some participants while working for some of the employers, but not available to participants working for other employers.

**Trust Fund EAPs**

Of the 85 administrators indicating health fund participants have access to an EAP, 62 (73%) indicated the EAP is sponsored by the health fund. These 62 health funds provide benefits for 235,000 participants. Administrators reported some differences in the organizational structure, financing and types of services offered by these EAPs.
Financing for the EAP can be accomplished through several means. In some instances the decision to provide an EAP is determined by trustees and funded with general health fund dollars. In other cases, the EAP may be required by the collective bargaining agreement, and the collective bargaining agreement may specify a separate contribution to finance the EAP. Five respondents reported the financing for trust fund-sponsored EAPs is based on separate contributions. A sixth respondent indicated EAP financing is determined by both health fund and separate contributions. Most administrators (55 of 62, or 89%), however, indicated the EAP is funded with available health fund contributions.

The organizational structure of an EAP sponsored by a health fund can be internal to the fund or external. Four administrators indicated the health fund sponsors an internal EAP, in which EAP services are provided by staff employed by the fund office. By contrast, almost all (90%) administrators whose funds have EAPs indicated their EAPs were external EAPs, in which the fund contracts for services with an outside EAP provider. Only one fund sponsored a blended EAP, a combination of both internal and external models with both contracted services and in-house staff.

In addition to differences in financing and structure, there is considerable variation in the length of time EAPs have existed. One-third of the trust fund-sponsored EAPs have existed for 12 or more years, while another one-third have existed for three years or less. On average, EAPs sponsored by trust funds have been in existence eight years.

EAPs provide a wide range of services centered on preventing, identifying and solving personal problems negatively affecting the productivity and health of employees. Personal problems addressed through EAPs may be related to family or marriage difficulties, acute or chronic psychological problems, career or job-related stress, financial burdens or legal disputes. Because the cause and effect relationships between substance abuse and these other problems are often intermingled, consultation with an EAP specialist can help employees define their problems and refer them to the most appropriate treatment or counseling services. In fact, about one-third (35%) of the 62 administrators whose funds offer EAPs indicated a purpose was to help participants find the most appropriate and effective services to help with their particular problem or set of problems.

Because of the complexity of problems related to substance abuse and the possibility that persons treated may lapse back into substance abuse, most (67%) of the trust fund EAPs actively monitor participants after they have completed substance abuse treatment. Twenty-six (42%) of these EAPs monitor participants for one year or more. For 15 (24%), monitoring is conducted for less than one year. Ten administrators (16%) indicated there is no follow-
determining the value of EAPs can be very difficult and often involves subjective judgments based on why trustees offer the EAP. Since an EAP involves a specific and planned commitment of fund resources, cost and rates of EAP use by participants can also offer important measurements. However, comparisons are difficult because measurements EAPs and funds use are not standardized. Furthermore, differences in the range and intensity of services offered to participants can affect both utilization and costs.

Utilization

Utilization is a difficult concept about which to gather information because fund administrators and EAP professionals do not use standardized definitions of utilization and do not report utilization (or receive utilization reports) in a standard manner. According to one expert, “Most of the variation in reported rates . . . is an illusion created by differences in calculation methods rather than true differences in program practices.”

Some common differences include

- Combining dependents and employees
- Including information-only telephone calls (resulting in referrals, but without benefit of the core assessment work of an EAP)
- Counting all active cases (including active clients from previous years who have continued to have some contact with the EAP).

EAP utilization may also vary depending on whether the EAP is used as a gatekeeper. Health funds using an EAP as a gatekeeper require participants make use of EAP assessment and referral services to obtain coverage for substance abuse treatment under the health plan. Forty of the 85 administrators (47%) whose participants have access to an EAP indicated EAP use was required to obtain coverage for substance abuse services.

As a result, it is important administrators and trustees be aware of the methods used to calculate utilization rates. Utilization rates can be helpful in assessing both the contract proposals and services provided by external EAP vendors and in evaluating the effect of in-house programs. Utilization rates can show how many participants actually use the benefit. (Twenty-two (35%) administrators whose participants have access to an EAP through the trust fund indicated a purpose of offering an EAP was to provide an additional benefit for fund participants.)

Administrators whose funds sponsored an EAP were asked to
report the percent of fund participants using the EAP in 1998 and the percent of fund participants using the EAP for substance abuse problems in 1998. Initial responses showed a wide disparity in utilization. Follow-up phone calls to administrators were used to standardize the information. The phone calls helped control for misinterpretation of the survey questions, but the difficulty surrounding utilization data mentioned previously made it impossible to standardize all factors.

Table I shows the percent of participants using EAP services as reported by 47 of the 62 administrators who indicated their trust fund sponsors an EAP.

**Cost**

The cost of an EAP depends on a number of factors including range and intensity of services offered, expected and historic utilization levels in a given group, and whether the EAP is internal or external to the fund. Cost information collected from the administrators of multiemployer health funds with EAPs would not necessarily apply to programs sponsored or operated by other organizations involved with multiemployer trust funds, such as unions, employer associations and individual employers.

Administrators were asked to report the cost of EAPs offered through the trust fund for 1998. Since some appeared to report very low costs, follow-up phone calls were made to each respondent to confirm that costs reported on the survey were annual costs. Since some had reported monthly costs, these were converted to annual costs for direct comparison.

Table II shows 1998 costs reported by 43 responding administrators. The same numbers are expressed in both annual and monthly terms.

Although retirees were included in the cost calculation for 26 funds and not included for 15

### Table I

| PERCENT OF PARTICIPANTS USING TRUST FUND-SPONSORED EAP SERVICES |
|------------------------|--------|--------|
|                         | AVERAGE | MEDIAN |
| Use of any EAP services | 10%    | 7%     |
| Use of EAP services    |        |        |
| for drug and alcohol   |        |        |
| problems               | 4%     | 2%     |

n=47

### More About Utilization Rates

Other rates related to utilization can provide more specific information and may be useful for evaluating the effect of EAP services, or the extent to which services are used. These rates include the following:

\[ Overall \text{ referral rate} = \frac{\text{cases that were given recommendation for outside referral}}{\text{total cases}} \times 100\%
\]

\[ Referral \text{ acceptance rate} = \frac{\text{cases that accepted recommendations}}{\text{cases that were given recommendations}} \times 100\%
\]

\[ Referral \text{ follow-through rate} = \frac{\text{cases that contacted recommendations}}{\text{cases that accepted recommendations}} \times 100\%
\]

\[ Services \text{ completion rate} = \frac{\text{cases that completed services}}{\text{cases that contacted recommendations}} \times 100\%
\]

Trustees and administrators may not typically receive reports from EAP vendors with these rates, but might consider requesting them.

### Table II

<table>
<thead>
<tr>
<th>ANNUAL EAP COST PER PARTICIPANT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Annual</td>
</tr>
<tr>
<td>Monthly</td>
</tr>
</tbody>
</table>

n=43
funds, the additional average annual cost for those including retirees was only about $1 per participant per year. There were only minimal differences in costs among regions and states. Eight of the 43 administrators (19%) who reported annual costs indicated participants share in the cost of the EAP. Cost-sharing techniques included use of deductibles and copayments, and participants paying the difference between preset allowable costs and actual costs for services.

Performance

Aside from cost and utilization, another way to measure EAP value is to look at the performance of the EAP in achieving specific program goals. For example, 12 administrators (19%) reported their health fund’s EAP was established to reduce fund costs. Administrators whose participants have access to EAP services were asked, regardless of source (fund, union, employer or employer association), for their opinions whether the EAP has reduced other specific fund costs. The results are shown in Figure 11.

The relatively high percentage of administrators choosing not to answer some questions suggests some uncertainty about the effect of EAPs, particularly in reducing workers’ compensation and disability costs. However, only ten of the 85 administrators (14%) whose participants have EAP access believed EAPs have not reduced costs for either disability, workers’ compensation or health plan.

Reducing turnover and job loss

Looking at Costs in a Different Light

To make Table II on page 9 more meaningful, the annual cost for EAP services based on the $25 median per year per participant is shown below for a range of fund sizes.

<table>
<thead>
<tr>
<th>Eligible Participants</th>
<th>Annual EAP Cost Based on the Median Reported Cost Per Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>$2,500</td>
</tr>
<tr>
<td>500</td>
<td>12,500</td>
</tr>
<tr>
<td>1,000</td>
<td>25,000</td>
</tr>
<tr>
<td>5,000</td>
<td>125,000</td>
</tr>
<tr>
<td>10,000</td>
<td>250,000</td>
</tr>
</tbody>
</table>

Of course, larger funds, or funds purchasing through a health care coalition, may be able to negotiate for more service within the price or a lower price than smaller funds or funds whose participants are geographically scattered. (See Appendix B for an example of funds purchasing EAP services collectively.)

In addition, trustees and administrators may want to look at cost and utilization together. For example, if a fund has 1,000 eligible participants and the annual cost to the fund is $25,000, then the EAP costs $25 per participant per year. If 5% of participants (1,000 × .05 = 50 EAP service users) use the EAP (however utilization is defined) in a given year, the cost per actual user of the EAP is $500 for the year. If 10% of participants use the EAP, the cost per actual user is $250 per year.
among members can be an important goal for unions. Employers can also be adversely affected by turnover. Among administrators whose fund participants have access to an EAP, 48 (57%) indicated they believe the EAP reduced turnover and job loss, while 11 (13%) indicated their EAPs did not reduce turnover and job loss. The remaining 26 (31%) did not answer.

Whether EAP services help participants get better quality care or more appropriate treatment is very difficult to measure. Part of the reason is quality and appropriateness are difficult concepts to define and measure in health care, especially in mental health and substance abuse. Also, multiple organizations can be involved in decision making and treatment. Nevertheless, one way to help assess the likely performance of an EAP service vendor is to determine whether the vendor’s services are accredited.

Accreditation programs establish industry standards and assess the extent to which organizations meet the standards. Two organizations accrediting providers of EAP services are the Employee Assistance Society of North America (EASNA) and the Council on Accreditation for Children and Family Services (COA). The EASNA accreditation program requires EAP providers show evidence they meet specific standards for documentation and implementation in areas such as administration, program operation, design and implementation, recordkeeping, confidentiality, staffing, supervision and staff development, among others.6

Peter J. Alles, M.P.A.
Assistant Director of Research

with assistance from Bryan W. Zoran, M.A.
Research Analyst

This study was conducted in cooperation with the Center for Substance Abuse Prevention (CSAP), as part of its Workplace Managed Care Substance Abuse Prevention and Early Intervention Project. CSAP is a division of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. More information on these organizations can be found at www.samhsa.gov/csap and wmcare.samhsa.gov/wmc.html.

### Fund Demographics

#### Industry the Fund Serves

<table>
<thead>
<tr>
<th>Industry</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>65%</td>
</tr>
<tr>
<td>Transportation</td>
<td>7%</td>
</tr>
<tr>
<td>Service</td>
<td>4%</td>
</tr>
<tr>
<td>Arts/entertainment</td>
<td>4%</td>
</tr>
<tr>
<td>Retail/wholesale trade</td>
<td>3%</td>
</tr>
<tr>
<td>Food</td>
<td>3%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>3%</td>
</tr>
<tr>
<td>Other*</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Includes maritime and longshore, landscaping, day care, printing, office and agricultural workers

#### Geographic Range of Funds

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>27%</td>
</tr>
<tr>
<td>Regional within a state</td>
<td>28%</td>
</tr>
<tr>
<td>Statewide</td>
<td>14%</td>
</tr>
<tr>
<td>Multistate</td>
<td>26%</td>
</tr>
<tr>
<td>National</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**n=184**

#### Region Where Largest Number of Active Fund Participants Reside*

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>41%</td>
</tr>
<tr>
<td>Midwest</td>
<td>38%</td>
</tr>
<tr>
<td>Pacific</td>
<td>14%</td>
</tr>
<tr>
<td>South</td>
<td>5%</td>
</tr>
<tr>
<td>Mountain</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Of 25 respondents selecting the Pacific region, 20 indicated the largest number of participants reside in California. Nearly half of the respondents from the Northeast region indicated the largest number of participants reside in New York.

**n=185**

#### Number of Fund Participants

<table>
<thead>
<tr>
<th>Active</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Funds</td>
</tr>
<tr>
<td>1 to 200</td>
<td>13</td>
</tr>
<tr>
<td>201 to 1,000</td>
<td>67</td>
</tr>
<tr>
<td>1,001 to 3,000</td>
<td>49</td>
</tr>
<tr>
<td>3,001 to 10,000</td>
<td>38</td>
</tr>
<tr>
<td>10,001 to 35,000</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>182</td>
</tr>
</tbody>
</table>

*Total does not equal 100 due to rounding.
Appendix A

There are as many ways in which early intervention and EAP services can be structured and delivered to fund participants as there are organizations connected to fund participants. The following diagram shows how fund participants may have access to EAP and other services through their fund, labor union, employer or an association of employers. The diagram also shows how some of these multiple organizations may provide services at the same time. While administrators are often in the best position to know what services are available to fund participants, the multiple organizations involved can make it difficult or impossible for any one person to be aware of all EAP and substance abuse activities affecting fund participants.

Substance Abuse and EAP Delivery Structures for Multiemployer Fund Participants
Appendix B

Case Study 1: Cooperative Purchasing Approach of Teamster Center Services, New York

Teamster Center Services (TCS) is a unique program that provides EAP and other services to approximately 28,000 Teamsters and their families in New York City, northern New Jersey and Long Island communities. TCS, which began offering EAP services in 1978, is structured as a voluntary employee benefit association (VEBA) and operates under a trust agreement. Each of the 19-member health and welfare funds appoints one management trustee and one labor trustee to the TCS Board of Trustees. The funds provide their own coverage for substance abuse and mental health benefits.

Substance abuse services provided directly by TCS to fund participants include evaluations, treatment planning, referrals and case management. TCS also provides substance abuse professional evaluations mandated by the U.S. Department of Transportation (DOT) for drivers testing positive on random drug tests. In addition, TCS negotiates discounted per diem rates with substance abuse and mental health treatment programs and offers precertification and case management services, and a hospitalization “umbrella” contract. TCS has contracts with inpatient treatment facilities throughout the eastern United States and has found that, in many cases, it is less expensive to admit patients to an out-of-state program rather than treating them locally. TCS offers participants a choice of programs matching their treatment needs and also offers services for problems unrelated to substance abuse and mental health.

Member health and welfare funds pay a monthly per capita fee for TCS services. In addition to the direct savings that TCS provides to members, the program produces significant cost savings for the participating health and welfare funds through its contracting and case management initiatives. TCS has found that contracting with providers directly produces savings of $1,500 to $3,000 per admission when compared with typical insurance rates.

Working with a population that has a significant number of drivers has presented many challenges to TCS. Drivers tend to work alone for most of the workday and, as a result, irregularities in behavior caused by substance abuse or a mental health problem can go undetected by supervisors and/or co-workers for long periods of time. Furthermore, drivers frequently work ten- to 12-hour days, making access to outpatient treatment difficult. TCS has addressed this issue by admitting more participants to inpatient care than is typical for most programs. Drivers are then able to return to work with more intensive treatment experience and drug-free time, and are usually able to attend outpatient follow-up treatment twice per week instead of four times, resulting in less conflict with job responsibilities.

Contributed by Andrew Johnson, M.A., CEAP, Administrator, Teamster Center Services Fund, Montefiore Medical Center, Bronx, New York.
Case Study 2: Internal Approach of the International Brotherhood of Electrical Workers Local 701 Health Fund, Members Assistance Program, Lisle, Illinois

The International Brotherhood of Electrical Workers (IBEW) Local 701 Health Fund has offered its member assistance program (MAP) since January 1987. Prior to 1992, MAP services were contracted to an external provider. Although generally satisfied with the provider's performance, fund trustees decided in 1992 that the MAP may be better utilized and more efficiently operated in-house, with professional staff employed directly by the fund and serving the specific needs of fund participants.

The MAP Advisory Committee, represented by management and labor, was expanded to provide guidance and support for the internal MAP. Utilization rates grew from 4.5% to 11% during 1993 and have remained at higher levels ever since.

At the same time, the medical costs per family using the MAP declined while the medical costs per family not using the MAP increased, as shown in the table below:

<table>
<thead>
<tr>
<th>ANNUAL FAMILY MEDICAL COSTS</th>
<th>BY USE OF THE MAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILIES USING THE MAP</td>
<td>FAMILIES NOT USING THE MAP</td>
</tr>
<tr>
<td>1993</td>
<td>$4,185</td>
</tr>
<tr>
<td>1999</td>
<td>$3,429</td>
</tr>
</tbody>
</table>

The MAP director is responsible for design, implementation and administration under employment contract with the board of trustees. The fund administrator monitors all administrative issues and MAP expenditures, working closely with the MAP director. A policy of clinical autonomy and strict rules of confidentiality are in place. Cases are reviewed by the MAP staff in consultation with a licensed clinical psychologist. Other clinical specialists may be consulted as necessary.

In-house MAP counselors have the advantage of working at the union hall in a close relationship with union officials. Counselors are able to respond immediately to requests by union officials, supervisors and management for assistance. This has enabled employee interventions at the worksite, the union hall, the apprentice training school and the MAP office quickly and efficiently with favorable results. Program literature, stationery and references to the program are marked by the union logo creating an awareness the MAP is an IBEW Local 701 Health Fund program staffed by union employees dedicated exclusively to the needs of its members. The close relationship of union officials with the MAP staff creates confidence in the program by union membership.

A potential drawback of an in-house MAP model is the concern that the close working relationships between MAP counselors and union officials may lead participants to question whether confidentiality protections are adequate. The IBEW Local 701 Health Fund MAP takes every opportunity to stress to participants the MAP’s confidentiality protections.

Another difficult area for in-house programs is the difficulty setting limits on personal involvement of well-meaning union officials and
supervisors in the clinical interests of the participant. The IBEW Local 701 MAP dedicates specific resources for training and education on the appropriate roles, boundaries and levels of personal involvement.

Services offered through the MAP include clinical evaluations and assessments for chemical and mental health issues at no cost to participants and dependents, referrals for treatment, comprehensive case management and follow-up services. The MAP also trains supervisors and union officials on drug testing policies and procedures, provides short-term brief resolution therapy, smoking cessation counseling and referrals, MAP orientations and training for apprentices and other union members at Apprentice Training School. The MAP distributes substance abuse, mental health and wellness educational and prevention materials, and contributes articles to the Local 701 newsletter.

The IBEW Local 701 MAP collects comprehensive utilization data including:

- Program admissions and readmissions for members, dependent spouses and dependent children
- Program admissions by type, including mental health and substance abuse
- Admissions rate by diagnosis
- Treatment outcome information, such as client evaluation of treatment providers, client self-evaluation and client evaluation of MAP services
- Member employment status.

Follow-up services are provided as needed on an indefinite basis. Chemical abuse cases are followed up for at least one year following treatment. Relapse prevention programs, individual counseling, self-help groups and other appropriate services are available to eligible fund participants and retirees and eligible dependents. There are no geographical restrictions. Although cases can be successfully managed out of state by telephone, more personalized efforts improve the chances for more effective services.

Contributed by George Maltezos, Director, IBEW Local 701 Members Assistance Program.
Appendix C

Multiemployer Funds

Multiemployer funds are vehicles for providing benefits to employees in unionized industries such as construction, transportation, service, entertainment, retail and wholesale, and manufacturing. The fund provides a centralized structure for administering the benefits of employees who may work for several employers within an industry in any given year. In general, multiemployer funds ensure benefits portability for employees as long as they work for employers participating in the fund.

Participating employers contribute to the fund in accordance with collective bargaining agreement requirements. The fund and its benefit plans are managed by a board of trustees composed of equal representation from management and labor. The board of trustees is charged with making plan decisions solely in the interest of plan participants.

For more information on multiemployer plans, see


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