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MANAGING MENTAL HEALTH COST

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- Benefit structures
- Utilization review
- Large versus small groups
- Mandated benefits

MR. ROBERT H. DOBSON: Frank Erdlen will be our first speaker. Frank has an MBA from Temple. His original experience was in the hospital area. He served as Director of Quality Assurance at a major acute care Society of Actuaries April 1989 institution in Philadelphia. He has also been involved in substance abuse outcome studies and has several publications on this topic from work he did at the University of Pennsylvania. He joined TAO in 1987. TAO is a wholly-owned for-profit subsidiary of Independence Blue Cross, which is the fairly new name of the Philadelphia Blue Cross organization. TAOs entire business is in the mental health and substance abuse areas.

MR. FRANK R. ERDLEN: My presentation will focus on three major areas, that are relevant to managing mental health care costs. These are:

1. Attempts to predict utilization of psychiatric treatment (mental health and substance abuse).
2. Various methods used to control costs.
3. Utilization review and managed care for mental health and substance abuse.

PREDICTING UTILIZATION

The basis for any reliable rating is a reasonable estimate or prediction of service used by a target group. The key factors involved in this process are:

1. Knowing the relevant attributes of the population.
2. Understanding the relationship between these attributes and treatment needs.

Given the current state of affairs in psychiatric treatment, you cannot project utilization of these services accurately or precisely. Utilization in this area is driven by behavior of the "unstructured" psychiatric service market and an unpredictable consumer. To clarify, I would like to compare the current situation in the medical/surgical environment with that in the psychiatric area.

In medicine, if you know the patient's age, gender, diagnosis, and comorbidities, the standard of clinical practice is such that you have a good idea of the frequency, duration, location, and intensity of treatment required for the patient's condition. Diagnostic procedures are relatively well-known, understood, and thought to be reliable. Measures (laboratory tests, imaging, etc.) are fairly well-defined and objective. Further, given the diagnosis, typical course of treatment, and some regional pricing information, you may have a fair idea of what costs will be incurred in treatment, hence, an estimate of risk. Appropriate prevalence rates will allow a reasonable predictive model.

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In psychiatric treatment, it is much more difficult to develop a meaningful model to predict utilization. There are diagnostic standards for mental health and substance abuse. The *Diagnostic Statistical Manual III Revised* (DSM III-R) is the principal reference for these diagnostic standards. The diagnostic process in mental health, however, is generally more subjective than that in medical/surgical practice. As in medicine, signs and symptoms form the basis of diagnosis. However, the signs and symptoms used in mental health are primarily behavioral and/or cognitive in nature. They often represent an exaggeration of behavior that under other circumstances could be considered normal (albeit undesirable). The diagnostician must evaluate the degree of exaggeration. In many cases, the reliability of the diagnostic process could be (and has been) questioned. With only the diagnostician's observations and histories that come from the patient or a collateral, verification of diagnoses is an issue.

Given a diagnosis, age, and gender, it will still be difficult to predict the frequency, duration, location, and intensity of treatment required for the psychiatric patient. There are a wide variety of treatment philosophies and differential responses to incentives, which make service utilization difficult to predict. This is, in part, due to the chronic nature of most psychiatric disorders and what may be a perceived ineffectiveness of some types of treatment.

A provider of psychiatric services will choose a course of treatment for the patient based on the provider's "philosophy of treatment," experience, and some measure of the severity of the problems. This process may result in an inpatient stay, day treatment, or outpatient care all with indefinite term. The same patient with the same condition seeing a different provider may be engaged in a completely different course, which may result in a very different utilization pattern.

Treatment outcome measures often do not suggest a "preferred" course of treatment, hence, wide variation is possible.

From a perspective outside the delivery system, there appears to be a lack of well-defined rules, hence, the delivery system appears quite unstructured. Outcome measures across many treatment modalities generally suggest limited effectiveness in many treatment choices. Controlled studies on alcohol treatment suggest that only 10-40% of patients undergoing any type of alcohol treatment are in remission two years after treatment.

From the consumer side, entry into the delivery system has in it a significant component of randomness. While there are some data on the incidence and prevalence of most major psychiatric disorders, these figures do not adequately explain who will enter the treatment delivery system, at what point they will enter, and how long they will remain there. These questions are key to predicting utilization of services.

People suffering from a psychiatric disorder:

1. may or may not experience acute symptoms signaling the need for care.
2. may or may not recognize the need for care.
3. may or may not seek treatment.
4. may or may not get better.

While all of these conditions exist in the medical/surgical area, the nature of psychiatric disorders and the influence of the patient's unique environment (family, social, work, etc.) results in consumer behavior which is far less predictable than medical/surgical experience. Further, since the majority of psychiatric disorders are chronic and compliance with ambulatory or "home treatment" is a function of the factors cited, the potential for many treatment episodes exists.

In summary, it would appear that the impact of differing treatment philosophies, the presence or absence of family and/or social support systems, specific patient characteristics and the effectiveness of treatment on these chronic disorders combine to produce very unstructured, unpredictable treatment experience. In the absence of well-defined and accepted standard treatment protocols and a measurable and understood treatment outcome, costs are managed primarily by benefit limits. Psychiatric utilization is driven by the unstructured market, unpredictable consumers with the economic constraints and incentives provided for in the benefit. The situation described above in no way obviates the need for reasonable psychiatric health insurance coverage. It just makes decisions about coverage levels more difficult to make. Payors have traditionally limited risk by providing "minimal" coverage. In the absence of a

well-structured delivery system, these limits are the most commonly used methods for managing mental health costs.

METHODS FOR MANAGING MENTAL HEALTH COSTS

The need for more effective management of mental health costs has become increasingly clear. Upward pressures on utilization and benefit limits stem from several sociologic and economic phenomena:

1. broader recognition of the "legitimacy" of psychiatric disorders,
2. a greater concern about the opportunity costs associated with untreated disorders,
3. a growing sense of moral obligation,
4. the increase of statutory mandated coverage levels.

In addition, the costs associated with covering some types of psychiatric care have been increasing at an alarming rate. In the last ten years, the percentage of an insurer's payout accounted for by psychiatric treatment has doubled on the average. The market for these services has become highly competitive and providers have developed differentiated products and aggressive marketing campaigns to take advantage of heightened public awareness.

Further, costs of providing psychiatric care are escalating even faster than that of medical/ surgical care (roughly twice as fast over the last ten years). In spite of minimal benefit limits, the effects of all these factors result in more money being spent on mental health treatment.

BENEFIT/RISK METHODS OF CONTROL

The traditional methods for managing mental health costs have been to assess risk based on the experience of some risk pool (community, group or other), to design a structure to minimize risk and then to rate the product in a manner that covers the assessed risk. This method can work reasonably well if the assumptions about incidence, prevalence, and standards of practice are known and predictable. However, these conditions do not describe the current situation in mental health.

Typical benefit/risk methods for managing mental health costs include:

1. Day and/or dollar (i.e., annual) limits and lifetime limits,
2. Use of copays and deductibles,
3. Exclusions,
4. Stop loss,
5. Migrating risk to providers,
   a. Capitation,
   b. Other prospective payment schemes, and
6. Migrating risk to employers -- self insurance.

These traditional methods have become increasingly ineffective in managing mental health costs. Further, exclusive reliance on these methods and the lack of explicit rules for providing care have encouraged the development of a delivery system, which is organized around benefit structure rather than cost/benefit ratios. The traditional indemnity benefit of 30 inpatient days and no outpatient days and no coverage for outpatient care (except minimal coverage in major medical) has supported an "inpatient-oriented" approach to treatment delivery.

Indeed, methods to manage costs must provide incentives for providers to use the least restrictive, least intensive treatment appropriate to the patient's condition. Benefit/risk methods alone cannot provide the level of management required to administer these incentives.

BENEFIT/RISK AND MANAGED CARE

As cost containment measures have received increasing attention as "partial solutions" to uncontrolled utilization problems, a continuum of containment mechanisms has developed. In order of increasing control, these mechanisms are:

1. Post-payment validation of charges
2. Utilization review (UR) -- (preadmission certification + concurrent review)
3. Case Management (UR with alternative treatment plans)
4. Managed care and provider contracts, HMOs with built-in UR features, PPOs

Each of these methods have relative costs and benefits. I would like to touch on a few salient characteristics of UR to illustrate some of these costs and benefits.

UR AND MANAGED CARE

The unstructured nature of the mental health treatment delivery system (i.e., the lack of rules) results in a limited benefit being consumed in what appears to be an "arbitrary fashion." The function of any effective UR system for mental health care is to define a set of rules for providing care that incorporates benefit limits, available treatment resources and applicable professional standards. Further, the UR system should assist in assuring that these rules are applied consistently and effectively.

The need for such a specialized review has created a niche for psychiatric UR companies such as TAO, Inc.

For the purposes or our discussion, I will use TAO as an example of the type of functions performed by a "typical" UR company.

TAO specializes in psychiatric utilization management including mental health and substance abuse. Our clients are payors, and we maintain an arms-length relationship with providers. Adjuncts to our utilization management services include custom reporting and research and evaluation functions. Products include UR, individual case management, managed care with an open panel of providers and managed care with a preferred provider organization.

The following statements describe the necessary elements in putting together a specialized UR function:

1. UR functions must be built using a decision support model. Clinical data and published references serve as the basis for these decisions, but decision trees incorporating other characteristics must be applied by reviewers with clinical expertise.

2. Managed care includes utilization management (UR and case management), quality assurance and methods for organizing providers around reasonable standards.

3. UR includes precertification of admissions, concurrent review, and review of treatment and discharge plans for all levels of care.

4. Case management includes UR components plus value-added features providing stronger utilization controls such as out-of-contract benefit management, second opinion, standards of care and a specialized management information system.

Internal systems required for UR include:

- professional reviewers and consultants who must represent appropriate specialties. All must be "retrained," since experienced professionals typically come from the provider sector. Care must be exercised to avoid the "capture" phenomenon.

- policies and procedures including internal quality assurance. Reliable tools for capturing relevant patient data must be developed. In medical/surgical review, this can be done in the paper equivalent of one page of data. Psychiatric review requires up to five pages.

- criteria sets and decision trees used with clinical data collected during reviews.

- a management information system.

- an appeals system to allow recourse for providers who have had requests for care denied.

The UR system must establish external links to eligibility/membership systems, claims systems, research, and client and provider relations. An effective UR system is based on clear contractual arrangements between the payors and subscribers and payors and providers. Agreements should at least define medical necessity, emergency care, and limits specifically in terms that can be applied directly to psychiatric treatment. Phrases like "appropriate, least costly level of care," and "harm to self or others" have meaning in this context. Providers must also understand the rules applied

by the UR process. Most must feel they can work effectively within the rules. UR functions require articulate, verifiable diagnoses and treatment plans.

Due to the same factors that create the random features of psychiatric utilization, criteria sets are not inherently right or wrong. They must, however, be developed considering the benefit structure, payors' goals and regional practice patterns. Criteria sets must include all levels of care available for use. They must be professional, reasonable, clear, and mutually exclusive, and able to accommodate exceptions. Criteria should address differential requirements of mental health and substance abuse at each level of care.

Sample Guidelines (not criteria) should be provided when a routine type of care will not be certified as appropriate service. This should be made explicit to providers. For example, TAO does not certify inpatient detoxification for uncomplicated cocaine dependence. Dual diagnoses cases pose special problems. Combined benefits should be considered to the extent that mandates do not preclude them.

Effective internal quality assurance must be developed. Review systems must not be permitted to compromise quality of care. An example of a review system is a cost control method that combines benefit structure with managed care principles. A benefit limit expressed in inpatient days is established through traditional techniques. Based on explicit trade-off ratios, these inpatient days may be converted to a fixed number of "units of care" (days, sessions, visits) in alternative settings. All care must be preauthorized by the UR company or department using a standard, precare or continued care assessment. In effect, the trades are reviewed and authorized during this process. Second opinions are sought at the discretion of the UR group.

Examples of the trade-off ratios are:

- two days in residential treatment facilities for one inpatient day
- three days in transitional residential (similar to halfway houses) or partial programs for one inpatient day
- three outpatient visits for one inpatient day (copays are used)

  Two outpatient limits are established:
  Standard: Up to 20 outpatient visits can be authorized per benefit period.
  Expanded: For patients who have a history of inpatient treatment (and outpatient visits are clearly an alternative to additional inpatient episodes), up to 52 outpatient visits can be authorized. All units of care used draw down against the day limit established in the benefit.

The major advantage to this type of model is that it contains incentives for providers to utilize appropriate levels of care. The alternatives to inpatient treatment are covered and reimbursed at reasonable levels. The managed care element is used to assure that the rules are explicit and observed and that quality is maintained. This approach, in our view, is the most effective means of controlling mental health costs.

MR. DOBSON: Our next speaker, Cliff Frank, has a master's degree in health services administration. He began his career with Blue Cross of Florida. He was their Director of New Product Development. Then, he moved to Pennsacola and ran an HMO called Medical Center Health Plan. He took that plan from inception to an 11% market share in the West Florida area in three years. His current practice in Jacksonville is a varied health care practice, but he has completed several mental health capitation arrangements.

MR. CLIFFORD R. FRANK: I would like to talk about the big push from open-ended systems to more limited-access mental health care systems and how those delivery systems affect the computation of rates for mental health programs. To give you an example of the impact, my company just went through one negotiation where the experience was $6.18 per member per month, or roughly about 9% of total medical expenses. That amount is before the contracts were let to specific mental health providers. After the contracts were let, the insurer's cost is now capped at $3.62 per member per month, or roughly 5% of total medical costs. The risk has ended up with the provider. That is fine if the provider can manage it. If not then the risk is going to boomerang, and there are going to be some problems downstream very similar to the ones in the HMO industry. Understanding the organizational structure of the contract community -- whether

or not it is an individual practice association (IPA), group of psychologists and psychiatrists, a group model, or a multispecialty group practice -- helps create long-term relationships between insurers and providers, because the structure has an impact on the organization's ability to delivery the goods. Similarly, another key issue is where the organization is in its life cycle. Is this a brand new entity, and are you going to be its guinea pig; or, is this an organization that has a long history of managing mental health care costs? The sponsorship of the contracting entity is another key variable. If it is a provider-sponsored entity, certain things can happen as opposed to it being a corporate for-profit enterprise or non-profit sponsored by a hospital or something that is put together by a major insurance company. Everybody has a different agenda that affects how they do business. It is important to understand that, because the different goals may conflict with yours.

Another major question is how are the providers going to organize their care? Are they going to use a mental health gatekeeper? We think that this is a good idea. It is basically a primary care doctor for mental health. If you are feeling depressed, you contact this gatekeeper; the gatekeeper performs some sort of evaluation; and then, sends you on to the next level of care if necessary. There is a mechanism for assessing and controlling costs, assigning the number of visits, the length of stay, or some level of care, and assessing appropriateness as you go along. Concurrently there has to be an available treatment alternative. In many locales that is not the case. You need the various range of services that Frank pointed out, and it can make a big difference if those services are available. For example, in adolescent care you may have a general psychiatric hospital or a psychiatric wing of a general hospital that does not have a lock-down unit. If you do not have a lock-down unit, you probably cannot use that facility for adolescent psychiatric for the severe cases because of the liability issues -- if the kid walks out, then gets hit by a car or shoots up some more drugs, then you could have all kinds of legal problems. If those treatment sites are not available and a provider says he is still going to do it for $1.87, you have to wonder how he is going to do it. It is not just squeezing as low as you can in price, because that is going to blow up in the provider's face and your face 12 months or less down the road.

Another key issue is the provider's mix between psychologists and psychiatrists. This also ties in to sponsorship. If you have a psychiatrist-sponsored IPA, not much care is going to be rendered by psychologists. Yet, the psychiatrist is not necessarily going to want to work for a psychologist's wages. So, what is going to happen? You may have access and quality problems; you may have psychiatrists signing up for deals they did not understand; and a year from now it falls apart. Similarly, if you have a group of psychologists with no access to psychiatrists because it is a psychologist-driven panel, you have more problems. You may have patients who really need some medical or psychiatric care, above the capabilities of a psychologist, who cannot get it or feel they cannot get it. What we have found to be a reasonable balance in terms of services is somewhere around 35% of psychiatrists and 65% of psychologists. It may be 50/50; it may be 35/65. If it is 85/15 the other way, you have problems, because your costs on the program are going to be very high. On the other hand if it is 15/85, you have quality problems, because you do not have access to the high level care.

The UR component can have a big impact. Again, it ties back to the sponsorship issue. A lot of deals struck with mental health programs are designed to provide insurers with a panel who will do its own UR. Providers are not capable usually of decapitating themselves. They are okay at capitating but not decapitating because they are just not equipped to say less is better. It is not in their nature. Hospital administrators cannot do it; doctors cannot do it; psychologists cannot do it in the context of their own practice. We recommend is some external entity -- be it from your company, an outside company such as Frank's, or someone else along the line -- to be the bad guy, because when that psychiatrist or psychologist wants to put the patient in the hospital because the patient is feeling depressed and you cannot make a determination that this is a necessary medical admission, someone has to be there to take the heat. If it is someone within the community, frankly, the other doctors will cut that doctor off from their private practice. It gets real nasty. You really do not want to be in that league yourself, but with your company you may. You certainly do not want the local providers doing it, because either they will not do a good job or, if they do a good job, they will not be in town after 12-15 months. This is because they will have been ridden out on a rail. It just is not something that works. You have seen it in medical coverage over and over again. In psychiatric care it is even more prominent.

OUT-OF-NETWORK BENEFITS
Out-of-network benefits in an exclusive provider organization are no problem. You can see the doctor signing the contract -- if you go anywhere else, you do not have any benefits. However, we are seeing a lot of point of service products where if you go to the network, you get 80% or 100%; if you go outside, you get 60% or 80%. There is a 20-30% penalty. That is fine, except that you begin to wonder. Is it 60-80% of what, a schedule amount or of the charge? If it is of the charge, you particularly have problems in providers waiving the deductible. If that happens, there goes your utilization assumption, and there goes your cost control and capitating in a program that has out-of-network benefits.

SEPARATING CHEMICAL DEPENDENCY FROM MENTAL HEALTH
Another important aspect that we have talked a little bit about already is separating chemical dependency from mental health. It is not the easiest thing to do. In fact, there are some keys. First of all, the user profiles are very different. To the extent that you have a high female content group -- a bank or school board, for example -- you are going to have generally higher mental health utilization. You will also tend to have lower chemical dependency utilization. The two seem to offset each other. On the other hand, if you have a construction company, where you have a high male content, the situation will probably be the reverse -- high chemical dependency utilization, low mental health utilization. In adolescent patients, you have some of everything, and it is all mixed up. You cannot separate it. You end up with the problem of dual diagnosis. You have someone who has an adjustment reaction, and they have a chemical dependency problem as well. Having the acute care or other lower level treatment facilities here becomes more important. You may have a case rate of 3 per 1,000 in adolescents and may be able to drive that down to a 1 per 1,000 admission rate by having the appropriate secondary treatment programs that deal with the problem. You are going to have 60 days every year with a lot of these people, because the dual-diagnosis people are real hard to treat. If your benefit package has inside limits that either combine the deductible and coinsurance or combine the 30 days into one package, it is a lot cheaper. If you capitate a mental health provider and they also are responsible for chemical dependency, you let them sort it out. It is their problem -- not yours. If you are dealing with one set of providers for chemical dependency and another set of providers for mental health services, you run the risk of them punting the patient back and forth. As the charges keep mounting upwards, it becomes a game of "hot potato," and the patient is the one who suffers.

LEARNING DISABILITIES
If learning disabilities are covered, then raise your rates, because they will cost you a whole lot of money.

MARITAL COUNSELING
A lot of plans included marital counseling, and they learned the hard way. It is highly stressful, and it comes under a different diagnosis but may be the underlying problem. It becomes the job of a good UR entity. Having good language in your contract becomes important.

WEIGHT CONTROL
Obviously, weight control benefits are big. I know you have excluded those benefits from your medical side, but a lot of this can slip in through a diagnosis of depression or treatment by hypnosis. There are all sorts of ways to get this covered. You have to make sure if you want to exclude it, that you exclude it all the way.

BIOFEEDBACK
Biofeedback is an excellent tool, but as an end in and of itself it can be very badly abused. You may want some specific inside limits on biofeedback. We have seen $85 charges come through for 8, 10, and 12 weeks; then six months later the patients come back through for another biofeedback cycle. It is just a real gold mine for some providers.

PROGRESSIVE COPAYMENTS
Progressive copayments are something that we have just seen in a few plans, where the longer you are in, the higher the copay.

The longer you are in treatment, the more charges the patient has to pick up. In some states that probably would not pass mustard in the state insurance department, but it does tend to have somewhat of a discouraging effect on open enrollment situations.

PANEL DISCUSSION

SUMMARY

A lot of these issues tie together, and it gets hard to sort out. It may seem like you are dealing in nickels and dimes, and that is probably true. The only problem is the money tends to compound, and it adds up pretty quickly as we have all learned the hard way. The mental health situation is extremely visible to employers, and I am sure it is very visible to you. You are probably tired of being beat up about it by your employers. Employers seem to be willing to tackle issues of employee choice in these subspecialty areas in ways that they have not been willing to before, so I think you have some new opportunities to deal with this situation that you have not had in other areas of medical specialties.

MR. DOBSON: Our final speaker is Ken Avner. Ken is Alternate Delivery Systems Pricing Actuary for the Illinois Blue Cross plan. They have over 300,000 members in HMO Illinois and another half million members in their PPO. His experience is from this context and specifically with an experiment they tried in mental health. Prior to his joining Blue Cross, he was a consulting actuary with Tillinghast.

MR. KENNETH S. AVNER: In one location in Illinois, my company had what was considered a major problem with mental health benefits, meaning psychiatric and substance abuse. We ran an experiment where we subcontracted for these services through a capitated arrangement.

It was said earlier that you could not have unlimited benefits. I am afraid in our experiment there are unlimited benefits, but they all have to go through this exclusive provider. Our subcontractor does all the preapproval, and actually provides the benefits; and the benefits are unlimited. I understand it is pretty hard to get approval for admission to a hospital.

What I am going to talk about is the capitated approach to mental health. Specifically, I will talk about the experiment we did.

There are three basic problems when you consider mental health benefits: high utilization, high rate of increase (generally the belief is it is out of control), and nonpsychiatric physician discomfort in managing mental health problems.

This last is very important. If I had to single one of these reasons out as the most important for our conducting the experiment, my guess is the third one is it. It was not so much the cost of mental health services, because people were willing to pay the cost. It is a relatively small part of the total premium dollar, but the people in our IPA, every time we would meet with them, would hit us with, "We do not know what to do about this," and "It is out of control," and "It is hurting us and the premiums of the plan in general," and "What can you do to help us?"

Obviously, the psychiatrists were not the controlling physicians in this IPA. In general that is the case. Sometimes there are political issues. You can get into provider relation problems when you try to capitate and the psychiatrists have any kind of control.

But, in our case, which is typical, we had a group of nonpsychiatrist M.D.s who are used to practicing the standard medicine they learned in medical school, and they suspect psychiatrists are nuts. When it comes to a mental health or substance abuse problem, M.D.s do not know how to interact with it, and they are very uncomfortable when somebody presents such a problem in their office. They just do not know what to do with it.

So just what is high utilization? I recently did an analysis in the Chicago area; I think we were running 23% of our days on psychiatric and substance abuse. As high as that sounds, it is low when compared to an indemnity plan. I think indemnity plans are up in the 25-30% of days. Also, there is a high rate of increase. I think we were going from below 7% of premium to over 9% premium in the last year. That is without any of the drugs, just the medical costs! That is a high rate of increase; something that gets a lot of attention.

WHY MENTAL HEALTH IS HARD FOR AN IPA TO MANAGE

You have heard a lot about why mental health is hard to manage already: no standard protocols, high variability of treatment success, high provider discretion, and the nonpsychiatrist M.D. discomfort with these conditions. The problem with no standard protocols is simple to understand on the medical/surgical side; it is almost as if your utilization review people can do things on the phone. On mental health that just does not work. Instead of being a half page, it is a five-page

procedure just to do the precertification; and the standard case manager procedures are just not effective. Even when contracting with providers, the norms available are not very good. That is why mental health is hard to manage using the common utilization review techniques.

The next point is the high variability of treatment success. This is familiar to anybody who has worked in this area. It seems these people never actually get better; or if they do get better, it is hard to predict before you start who is going to get better and what part of the treatment really will do it.

I recently received a document that one of our consulting psychiatrists put together. She describes adolescence psychiatric hospitalization in a very negative way:

> The usual therapy scheduling includes five times a week with the psychologist, three times a week with the psychiatrist, once a week with the family, and a variety of group meetings. The cost is about $1,000 per day. Length of stay varies from a couple of weeks to several months. Sometimes there is strong pressure to prolong stays by delaying necessary tests, lack of discharge planning, and appealing the insurers decision, and even by threats of suit. Most treatment plans are vague and subject to frequent change. It is perhaps not surprising that when the insurance coverage finally runs out, discharge is quickly accomplished. Most teenagers receive a diagnosis of major depression, but with those honest enough to diagnose conduct disorders or school failure or mention that the parents are inadequate to supervise the care for their children, they will justify the hospitalization on the grounds that the only source of payment is medical insurance.

MENTAL HEALTH COST CONTAINMENT STRATEGIES

The four things I wish to discuss in the area of mental health cost containment strategies are benefit design, utilization control, low cost alternatives, and selective contracting with providers. I would say in the place where we ran the experiment we did all of these things. If you notice, as you progress through this list, it follows the standard way to do cost containment. For any kind of benefit, first put copays in or at least start playing with them. If that does not work, put on some kind of utilization control, maybe a precertification. That might be followed by a PPO with discounts -- a lower cost alternative. Maybe, try to change sites. Then, maybe try a genuine PPO, where only certain providers are allowed. Finally, just capitate.

Those of us who work with HMOs and still believe that they really are a cost control alternative, suggest skipping the other steps and testing directly the HMO concept of capitating the providers. It is interesting when you put the five strategies of controlling on a list as I have done. It is reminiscent of the way Kaiser started. Sidney Garfield actually tried to set up his practice in all the standard ways; and when nothing worked, only then did he consider some kind of prepay concept. We felt it was time to see whether or not capitated mental health would work. There is a lot of pain in implementing capitation, and that is really a large part of my presentation.

THE PITFALLS OF CAPITATION

Capitation is expensive. The people you capitate are going to provide service. If an alternative method of controlling those costs is developed, this new way's savings devolves on your capitated provider, not you. Maybe, capitation is not as expensive as the alternative, but it is not particularly cheap.

Capitation is restrictive. You immediately take away all kinds of freedom of choice. Anybody who has been working with an open option HMO, where you see both sides of this, understands. To some extent, people expect the HMOs to be restricted, so you can get away with the capitated arrangements. The patient cannot go to any hospital and cannot go to any provider, because he is in the HMO. You can get away with it in an HMO. Try doing that in a traditional plan, and I think you are going to hear yelling and screaming.

Then, there are marketing issues. We have a lot of problems with people concerned that we were going to upset the physician relationships. Also, frequently there are employee assistance program (EAP) relationships, and the hospitals where people are used to sending their children for psychiatric care. Sometimes the EAP/hospital relationships are especially hard to break.

There are provider relations issues. When psychiatrists have a strong political effect on or control of an IPA, you may as well give up on capitating a subcontractor. It will never be given a chance.

Finally, we get to the biggest problem (because it is my problem!). Capitation forces the actuary to microprice. By this I mean separating a small benefit from a big program and being scrutinized about every utterance made concerning this limited set of conditions. I am always uncomfortable when micropricing, taking my benefit package apart into little pieces and letting somebody take pot shots at the little pieces. My belief is generally, if you squeeze one place, it will only get larger somewhere else.

FINANCIAL EFFECTS OF CAPITATION

There are some things that should be kept in mind before you decide capitations are wonderful, there is nothing to worry about, just go ahead and do it, and you are going to save a ton.

The first thing we have to keep in mind is that psychiatric days are cheap days. They are low cost days. They may be less than half the cost of your average medical day. Certainly, they are less than half the cost of your nonpsychiatric days, especially in an HMO setting where you have high intensity, and the nonpsychiatric days are generally acute care days and very expensive. Remember psychiatric days may be 20% of your days, but they are probably not even 10% of your hospitalization costs.

Second, we must consider discounts. I assume you have discounts. The discounts can give you a very strange effect. In one hospital that had a significant amount of our psychiatric days, we were on a straight per diem. We ended up losing money on psychiatric days on our discount arrangement. Because of the wide difference in the cost of the psychiatric and non-psychiatric days, our wonderful discount arrangement ended up adding to the cost of the psychiatric days; at the same time it saved significant sums on the acute care days. That is interesting when you go back to your marketing and provider relations people, and you explain that although you have all these days, it is not the way they think it is. I am not saying it cannot be worked out, I am saying it may catch some people unawares. You may have to cut a different deal with your hospital if you take away all the psychiatric days and move them somewhere else.

Also, similar to considerations concerning discounts, your physicians' incentives in an HMO may be strangely affected by what you do when you carve out the mental health part. Again, maybe it is based on days, maybe it is based on certain kinds of cases. It is another complication that needs to be considered. Finally, I would not recommend to anybody to go to capitation without creating a little slush fund on the side for the stuff that falls through the cracks. Slush funds cost money.

Add capitation, show savings, and you may still spend time explaining why the results are not better. When putting the program in, because of the interplays of the other things, you do not save quite as much as you think you are going to save. Do not say you are going to get rid of 20% of the days, so you get 20% of the premium. It does not work like that. Do not even say that the cost of psychiatric and substance abuse in my HMO is 9%; and therefore, I have 9% that I can just move off to the capitation or if I can cut a deal with the capitated at 5% of premium, I am in great shape. It does not go quite that simply.

There is an upside to getting mental health costs under control, and I would be remiss not to mention it. There are a number of studies showing the startling costs of somaticizers -- those who have no physical ailment but demand treatment of symptoms, which are manifestations of mental problems. If we can effectively get help for these "worried well," our other medical costs would be reduced.

CONCLUSIONS FROM THE EXPERIMENT

So, we ran the experiment and what happened? First, inpatient days plummeted. Like any HMO, it is not unusual to see inpatient days for mental health at 60-80 days per 1,000. If you put in a good outpatient oriented mental health program, as we hope ours was, you can expect that to drop to three or four days per 1,000. It plummets.

On the other hand, outpatient visits soared. It is almost as if the people who we contracted with go out of their way to do outreach programs, so they really want everybody in their clinics. The provider effects were minimal. That is because there were relatively few hospitals involved. Maybe they have not really geared up yet to turn empty beds into psychiatric beds. We went to

every hospital and explained that before there was an admission, there would have to be a precertification from our UR people. Therefore, the provider effects were less than we thought they would be.

The financial effects were not much. Let's say we were at 7% of premium, and the deal we cut was at 3%. Therefore, we saved 50% based on this deal, i.e., 3% of premium. The 3% of premium is significant, but it really is not as much as people were hoping they would get, especially when one starts adding on the ancillary benefits such as prescription drugs. The savings get diluted. It is not clear what effect having a really comprehensive psychiatric benefit has on a nonpsychiatric cost. The financial effect is not enough to make a lot of people happy.

The jury is still out on the conclusion of our experiment. There is not enough experience to really be sure what is going on. We have seen outpatient visits soar and inpatient days plummet. I think we have 2-3 admissions. Before we had many, many more. It is very hard to get into the hospital when these guys are doing your UR. They will do all kinds of things to treat you on an outpatient basis, but the basic assumption of the provider we contracted with is that inpatient care is almost never appropriate care.

MARKET PERCEPTION OF A MENTAL HEALTH PROBLEM

I would like to talk a little bit about the marketing problems we faced. We did some market research on this. When our marketer surveyed smaller groups and talked to them about mental health benefits, the answer he received was, "What is all the fuss?" We can see from our statistics that the problems are at least as bad in the small groups as they are in the large groups. It is a difference in perception rather than a difference in reality.

The EAPs, which generally do a lot of mental health referrals because they get the mental health problems first, can have a problem in that they can feel threatened. We have seen that problem in some major employers with big EAPS. They did not want to have anything to do with this program.

I mentioned before that within an HMO the market perceives that you are going to have restricted access, so the access restriction was not as big a problem as I think the marketing people thought it would be before we made the change. I should also point out one reason why this experiment could work reasonably well is that a single IPA covered the area. It was a relatively small area, so we could take the UR that the single IPA was doing completely away from it and give the UR to someone else. If we did that in Chicago, where we contract with 80 different entities, it is not going to be nearly so simple. It is not clear whether or not we will bring this concept to Chicago.

BEYOND THE EXPERIMENT

How to extend the capitation concept beyond our HMO is fraught with problems. We could probably spend at least two or three hours just outlining them. I have spent days working with the provider affairs people on how you take this program and put it into our PPO or put it into our traditional coverage on some kind of nonexclusive basis. I guess there was some talk about that before. It is not easy. We have thought about all kinds of things. I do not think we have a good solution to it.

In the area where we did the experiment, the people who are doing the UR have a single site, and all the outpatient visits are done there. It is a relatively small area. You cannot cover Chicago with a single site, which means you have a major investment just to bring the capability to deliver this concept to a major metropolitan area. I think they feel they need 15-20 sites to cover Chicago. You cannot make people travel for an hour every week just to get to an outpatient visit. If you do, they will really need psychiatric care!

MR. DOBSON: In evaluating experiments like this, you have to view the alternative, and the alternative is continued high increases in the proportion of the health care dollar that is going to mental health. Even though the savings you get from instituting some of these programs may not be as great as you would like, I think it is a savings compared to the alternative of just letting it run loose.