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MANAGING MENTAL HEALTH COST

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- o Benefit structures
- o UR or utilization review
- o Large versus small groups
- o Mandated benefits

MS. LYNETTE L. TRYGSTAD: The topic of mental health cost is a hot one in the health arena today because mental health costs are rising much faster than any other health care cost. Before a problem can be solved, the causes must be analyzed. Probably one of the biggest causes is the lack of stigma attached to someone seeking professional counselling. Moreover, our society may have gone overboard in defining what addictive behavior is and when it is appropriate to seek professional help. We may have overutilization, unnecessary utilization. At the same time, we have providers openly marketing to consumers rather than waiting for referrals from a family doctor, schools and so on. This marketing is often of an emotional nature and is particularly aimed at the adolescent market. Billboards or TV and radio advertisements are very descriptive. One advertisement showed an open grave with people gathered around for what is obviously the burial of a child who committed suicide. The next screen flashes the words, "This didn't need to happen if you had taken your child in." A third factor in the rise of mental health costs is the difficulty in diagnosing the problem. The diagnosis may be as general as a conduct disorder. Along the same line, providers do not have protocols for treatment. This causes difficulty in assessing the appropriate course of treatment, and traditional utilization review techniques have not been successful to date.

The easiest solution to escalating costs is to reduce benefits and know what your costs could be at a maximum. We think the better solution is to try to manage this area of health care cost, which is the topic for this panel discussion. This approach provides not only a control on costs, but also better treatment which is more effective and less costly.

The three speakers are John Fritz, Eugene Hill and Sandra Hittman. John Fritz is in the Tillinghast Irvine office and has been in the insurance business for 23 years. Initially he practiced in both the life and health areas. For the last five or six years he has

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specialized in health and, particularly, in HMO types of health consulting. John will present a general definition of the problem from an employer perspective. Eugene Hill has been the president of U.S. Behavioral Health for the last two years. He has an MBA in health care. He was a hospital administrator, and he worked in an HMO and insurance company. Sandra Hittman has a Master's degree in psychiatric nursing. Early in her career she worked at a community health center in Chicago. Sandra has also had her own company providing patient relations and customer service consulting. She now works for Preferred Health Care as a regional marketing manager.

MR. JOHN F. FRITZ: At the general session luncheon, Dr. Tony Alessandra spoke on the topic of customer-driven service. He talked about finding the customer's needs and then filling those needs. In the case of group health insurance, our customer tends to be the employer. What I will cover is the employer's perspective of mental health and substance abuse cost.

The employer is concerned about the entire issue of rising health costs. Mental health and substance abuse costs are just one component. The employer has a hard time understanding why his costs are going up 20-30% when he reads that overall CPI increases are in the 4-5% range. Even if he looks at the medical inflation portion for CPI, the increase is only 8-10%. However, medical CPI is only based on a marketbasket of products and services. It measures how the cost of these products and services are increasing. It does not include utilization, which has tended to be a very big factor in increasing medical expense trends. It also does not include things like cost shifting, new technology and so on.

Besides explaining what medical CPI measures, we also have to explain that certain pieces of medical costs are going up faster than others. One of these components is mental health/substance abuse, which is our topic. For many employers this component is the fastest rising portion of their medical costs, and there is major concern about this area.

The table below shows what happened to inpatient benefits for mental health and substance abuse over the five-year period from 1983-1988. It shows the percentage change based on the experience of 21 large employers.

	Cost Per Member		Admits/1000
	Cumulative	Annual	Cumulative
Inpatient Mental Disorder	132%	18.5%	37%
Inpatient Substance Abuse	188%	23.5%	47%
Medical/Surgical	-	-	(25%)
All Benefits*	71%	11.5%	N/A

* Includes all medical benefits. The outpatient component alone is 142% cumulative or 19.5% per year

The cumulative increase is 132% for mental disorders and 188% for substance abuse. During that same period, benefits, including inpatient and outpatient, increased 71%. Mental health and substance abuse costs are a part of that 71%. On an annual basis, the inpatient mental health component increased 18.5% per year; substance abuse increased 23.5% per year; and the all-benefits component increased 11.5% per year. When analyzed from another perspective, the admission rate per thousand increased 37% for mental disorders and 47% for substance abuse. At the same time, medical/surgical inpatient days decreased by 25%. So, is it a problem? It definitely is. Incidentally, the average length of stay for mental health and substance abuse also increased during this time period, while the medical/surgical average length of stay declined.

Part of the reason for this increase is the growth in the supply of providers for mental health and substance abuse services. Traditional economic theory states that if supply goes up and demand stays relatively stable, costs should go down. However, this does not happen in health care. Despite the growth in supply, psychiatric hospital rates have increased very rapidly. It is interesting to note the differences by geographic area. For example in mid-1989, the average psychiatric hospital per diem cost was $613 in Philadelphia, but only $293 in Dallas.

We also have a situation whereby benefit designs actually encourage more expensive utilization by channeling the usage to inpatient settings because benefits are better for inpatient compared to outpatient. We also have a phenomenon occurring primarily in the juvenile area where courts are ordering treatment, rather than detention, as the sentence. This has spawned something called "warehousing," wherein juveniles are detained in psychiatric hospitals rather than in other types of institutions, or requiring parents to take responsibility. Even the courts are not working for us.

Another element is the popularization of psychiatric therapy. There are some segments of the population where it is actually a status symbol to say "I'm going to my therapist." As Lynette mentioned in the introductory remarks, cost control is difficult. The treatment or the conditions are somewhat subjective and much more difficult to deal with. Therefore, the control is more difficult. Also, we have state-mandated benefits. Over half of the states have mandated benefits for mental health and substance abuse.

I have already mentioned the supply side of providers. There was a 39% increase in psychiatric treatment facilities from 1979-1986 in the United States. Then in the next year alone, 1986-1987, psychiatric hospital beds jumped 28%. Also, according to the American Psychiatric Association, psychiatric practitioners increased from 50,000-250,000 in the five-year period 1982-1987. Employers are undoubtedly concerned about overall costs, but they also are concerned about the escalation of costs. There is more demand for accountability. Employers want to know where these cost increases are coming from. And they want them fixed. Many are rethinking their benefit strategies. Some believe national health insurance may be a solution. One good thing that has come from this is that employers are more willing to look at innovative approaches. They are willing to look at possible solutions that may not have all of the proof that they work. One of these approaches is the segmentation of benefits, like mental health and substance abuse.

The typical approach used to control mental health and substance abuse costs was to limit benefits. The industry recognized that these conditions were subjective, hard to measure, and difficult to control, and the solution was to limit these benefits as a means of control.

A 1989 study by the Bureau of Labor Statistics researched how benefits are limited. The study was based on nonagricultural employers and covered 31 million employees. The study found that generally less than 25% of the groups provided mental health benefits somewhat similar to benefits available for other types of illness.

In the case of inpatient rehabilitation for alcohol abuse and substance abuse, the benefits are similar to benefits for other illnesses only 15% of the time or less. In fact, a large percentage provides absolutely no coverage. Another somewhat interesting fact is that benefit designs often differ between mental illness and alcohol/drug abuse. Only rarely in these 31 million employee cases were the benefits actually similar.

Have these limitations worked? The resounding answer is absolutely not! We have runaway costs in the mental health and substance abuse area. In fact, in the view of some, with no control on these costs, other health care costs are affected as well. Under that scenario, if we can control mental health/substance abuse costs, we can better control other health care costs, too.

Another cost to employers is absenteeism. There is no doubt that a lot of absenteeism is created by substance abuse, for example.

If the traditional approach of limiting benefits is not working, what are the solutions? What are employers willing to try?

The management of mental health and substance abuse services is becoming more and more popular. Many employers are considering or already have an employee assistance program (EAP). If an employer already has an EAP in place and then introduces a managed mental health and substance abuse program, it is very important to closely coordinate the two.

The traditional approach taken by an EAP is to assess an employee's needs and refer the patient for appropriate diagnosis, treatment and assistance. Sometimes that process runs counter to what a managed health care program is trying to do in terms of containing costs. So, it is important that the EAP and managed mental health program work closely together rather than against each other. However, some EAPs provide a much broader spectrum of services. Some offer short-term counselling, and some have case management, gatekeeper, and cost containment capabilities.

The employer has several options. First, he can revise the benefits. In the past when we said revise benefits, that usually meant cut benefits. However, I suggest changes such as offering higher outpatient benefits, rather than the use of higher inpatient benefits that encourage inpatient utilization as a better way to cut costs. This is especially true for substance abuse where it has been proven that outpatient treatment may be the most appropriate treatment in 70-80% of the cases.

A second option is to carve out the mental health/substance abuse area and deal with it in a separate way. An HMO may not be set up to deal with the mental health and substance abuse component in a way which limits the cost. The traditional HMO approach to mental and substance abuse has been to greatly limit the benefits in order to control these costs.

Another option is to strengthen existing cost controls. Examples of this are higher penalties for failing to notify UR and audits to determine the effectiveness of existing cost controls. Other possibilities are to use specialty case management firms and/or use mental health/substance abuse preferred provider organizations (PPOs) or exclusive provider organizations (EPOs).

One advantage of using specialty case management firms is the resulting access to a greater knowledge of alternative, cost-effective care available in the community. Also, the staff psychiatric advisors interact more frequently with the provider community and are able to deal with issues better. Mutual respect between the two is evident which allows the UR function to work better. Also, there exists a stronger promotion of discharge planning and aftercare which reduce readmissions. There is an emphasis on family participation in the treatment, which helps address the warehousing issue. Close monitoring of psychiatric medications to guard against overuse of medications occurs. As I mentioned before, it is very, very important to closely coordinate an EAP with the managed health care component. Specialty case management firms are more accustomed to such coordination, and it is therefore more likely to happen.

In the case of specialty PPOs or EPOs, there is more focus on practice patterns during the provider contracting process. The provider community is not in agreement on the use of inpatient treatment. Some think inpatient treatment should be widely used, while other well-respected, quality providers feel treatment should occur in an outpatient setting. When networks are put together, specialty PPOs and EPOs seek those providers who subscribe to the latter view, that is, to limit the amount of inpatient treatment and solve problems in an outpatient setting if at all possible. Obviously, discounts may also be significant with these provider arrangements, especially if the market share is large. However, to take advantage of these discounts, channeling capability of the benefit design must be very strong. We support more channeling or higher penalties. Generally, we encourage a 20% differential for medical care. However, for mental health and substance abuse, 30% or more should be considered.

Obviously, quality is an important consideration, but it is difficult to measure. Interestingly, many believe that employees are not equipped to find quality carriers on their own. By having a network of PPOs or EPOs in place, there is much greater likelihood of dealing with quality providers. In fact, even primary care physicians are not really equipped to recommend quality providers for mental health and substance abuse. From this standpoint, PPO/EPO networks provide a good service.

I have already mentioned accountability. It is necessary to be able to evaluate how the plan is doing. Is managed care really working? The best means of evaluation is to have data before and after the introduction of managed health care. One should measure

inpatient days per thousand of covered members, the cost per inpatient day, and mental health/substance abuse cost as a percent of total medical cost.

It is also important to evaluate quality. One way of doing this is to compare employee complaints before and after the managed program was introduced. Not just the number of complaints, but the nature of those complaints, possibly even monitoring physician complaints. If the managed health care program is working, the readmission rate should decline. Those are areas that one can use to measure quality.

My presentation has been slanted mainly toward large employers. It is the large employer who is trying to solve the problem and has the leverage to do it. But what about the small employer? An individual small employer will not be able to solve this problem himself. He must rely on the insurance industry to provide products he needs. The issue of affordability is even greater in the case of the small employer. Specialty PPOs and EPOs could serve an important function for small employers. I encourage you all, as members of the health industry, to consider how you might fill this need for these employers.

MR. EUGENE D. HILL: My objectives are twofold. The first is to encourage your interest in the area of managed mental health because those of us who are attempting to manage these costs need your expertise and assistance. We are frustrated by the lack of data, the accuracy of those data, and the benefit designs that constrain our ability to work most effectively. The second objective is to demonstrate some of the relatively unique characteristics of mental health and substance abuse which we believe make traditional managed care methods unsuccessful and to give some alternative suggestions. My presentation covers four areas. John has covered the problem fairly well, but I will also. Next, I will discuss behavioral health utilization and benefit pricing. Finally, I will suggest some strategies for managed health care for mental health and substance abuse.

The problem is fairly simple. Costs are rising dramatically, and the quality of care is in great doubt. By quality of care I mean people are not getting well. We are spending a lot more money, taking up a disproportionate share of our resources, and it is not resulting in improved outcome. That is a problem, and it needs to be addressed. Expenditures are increasing about 27% annually. Mental health and substance abuse components represent approximately 25% of overall medical costs. The ratio varies tremendously by geographic area and by group characteristics, but it has doubled in the last five years. On the low side, the portion of plan costs attributable to mental health and substance abuse is 10-12%. On the high side, it is 40% based on the data available. I will give you some examples why I believe this is understated due to coding and other errors.

Another element of the problem is the dramatic increase in stress-related disability claims. People who work with worker's compensation have noted that stress-related disability claims now represent almost half of the total claims and are increasing dramatically. An employer analyzes behavioral disability costs, he reviews three discreet cost areas. The first area is the absolute amount spent on all nonoccupational medical benefits and on mental health and chemical dependency care. It should be noted that people who are chemically or mentally impaired also have a disproportionately high

usage rate of other medical benefits. The second area is benefits paid under worker's compensation for stress-related disability claims, including the well-documented higher increasing rate of accidents by people who have chemical disabilities. The third area is the somewhat intangible, but real, area of employee performance, absenteeism, turnover, theft and lost productivity that results from people who have disabilities that could be addressed, but are not.

To quantify how dramatic the expenditures are for people who are chemically dependent, Blue Cross in Philadelphia studied the utilization of hospital days for nonchemical dependency problems by people who are chemically dependent. The utilization was 10 times that for the control group who did not have chemical dependency problems. It is also important to note that chemical dependency impacts a whole family unit. One of my colleagues refers to this as the contagious nature of the disease. The relatives of people who are chemically dependent, but are not themselves chemically dependent, use 50% more hospital days per year than do those who do not have chemically dependent relatives. The cost of these problems cascades through a benefit plan.

Why is all this occurring? John spoke about some of the reasons, but I will briefly cover some as well. There is no provider price regulation. The problem is not just the glut of providers, but the providers' perception that there is absolutely no price sensitivity to what they charge. They can charge whatever they want, and people continue to pay the bill. This is also true for inpatient facility programs. As the number of hospital beds increase and the occupancy rate decreases, the providers are simply raising their charges. In Houston there are 13 freestanding psychiatric hospitals, 10 of which have been built in the last five years, and the prices approach $1,000 per day. There is no basis in capital equipment or in technology that could even remotely justify that high a price. It is flat-out greed. Those of you who follow the public markets know that all of the psychiatric hospital chains are doing better than medical/surgical chains. Their earnings are in the range of 25-30% compounded annually. They have had a bonanza, and they have had a bonanza on your dollar.

State-mandated benefits are also a problem. Two kinds of problems exist with state-mandated benefits. The problem that is more perceived than real are mandates to cover services provided by nonphysicians. I believe that covering services by nonphysicians in a controlled environment is a good investment since unit costs are reduced. Nonphysicians do not have a bias towards medication or inpatient admission. There is very little evidence that higher levels of training result in better outcomes. The real problem is that mandated benefits lock in reimbursement bias for inpatient care. Providers simply respond to the benefit design. If the benefit design covers inpatient care more generously, providers furnish inpatient care, and the cycle reinforces itself.

The destigmatization of mental illness has been very good in our society because it enables us to treat people earlier. Mental illness and substance abuse should be viewed similar to other chronic diseases such as diabetes. We need to intervene early and engage the patient in self-help. In so doing we can be more clinically effective, as well as more cost effective. If we penalize early access and impose substantial financial barriers to getting help, we will simply exacerbate the problem. People will eventually have a bigger problem which requires very expensive help, and that help could be less

clinically successful because the problem is more severe. The popularization of psychological help could also be described as no-fault mental health. As we become increasingly aware of the biological bases of some of the mental disorders, it is no longer viewed as bad patenting if your child needs assistance. Also, as therapeutic improvements become well-known, people are increasingly interested in getting help.

On the other side is the stigmatization of chemical dependency. This is also a positive turn in our society. But the result of this is that people will then seek help. For example, as companies increasingly require drug testing, more people will seek treatment because they might otherwise be unemployed.

Finally, there has been a massive decrease in public sector expenditures over the last 10 years. This is another cost transfer from the federal and state governments to the private sector. This is a contributing factor to increasing costs.

Why is quality an issue? Because there is no standardized treatment. Misdiagnosis is the rule, not the exception. Professional consensus is lacking. Generally speaking, the psychiatrist believes everything can be treated with drugs and is biologically based, the psychologist thinks he can talk you through everything, the clinical social worker thinks the problem is society, and the marriage and family counsellors think everything has to do with the relationships within the family unit. It should also be noted that most practitioners are in solo practice. They go through a training program, enter their professional career, and then have relatively little interaction with their professional colleagues. As a result, the dissemination of research into effective treatment practice is absent. Finally, there is difficulty in obtaining objective measurement of improvement. X-rays, laboratory examination and double-blind studies are not possible. This leads to very high rates of recidivism and a high level of noncompliance by the patients.

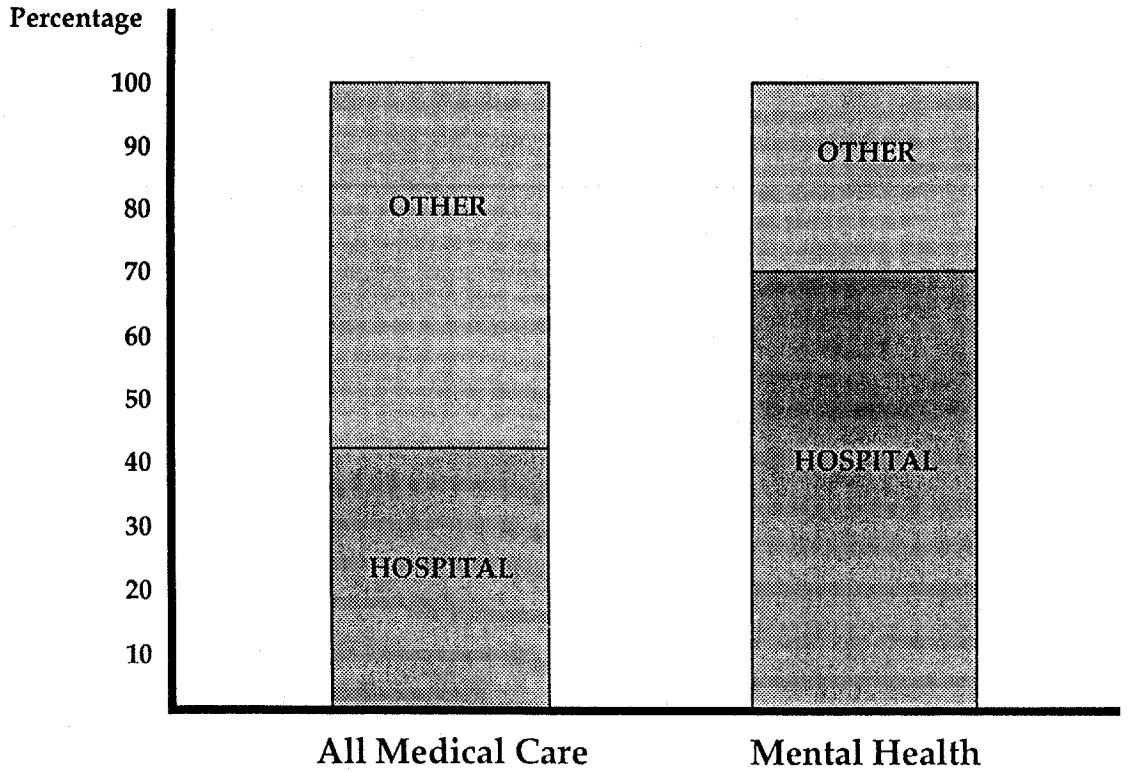
One of the greatest anomalies I saw when I first entered this area is that we spend twice as much of our money on hospitalization for mental health care than we do for medical care (Chart 1). Yet there is no need for the technology required in medical care. So why are we spending twice as much of our dollars for hospital services on mental health? I would argue it is because providers are responding to benefit design incentives.

Another characteristic of utilization is that up to 75% of the people have some need for some medical care during a year, but less than 10% of the people in our population seek mental health care. Epidemiologic data show that fewer than 15% of the total population have mental health or substance abuse problems. Another phenomenon is the difference between the prevalence of disease and the incidence of disease. Prevalence reflects the percent of the people in the population who have a particular disease. Incidence reflects the percent of the people in the population who actually seek treatment for a disease. As an example, there is 100% compliance for obstetrics or maternity; whereas, in mental health and chemical dependency, because of the stigma, there has been a gap. The gap is closing, which accounts for some of the utilization increases. People who have not sought treatment in the past are now seeking treatment.

The data I have quoted reflect a managed care environment. For a nonmanaged care environment, the numbers are probably doubled. That's how much inefficiency exists.

CHART 1

Health Care Expenditures



The vast majority, as many as 90% of the cases, could be treated for less than $1,000 a year. A very small number of patients require more costly care due to the need for inpatient treatment. When an admission is required, the cost is about $6,000 a year. Those not requiring an admission can be treated very successfully for between $600-800.

Based on CHAMPUS data, 46% of outpatient mental health users have 1-5 visits and 38% have 16-20 visits. Only 16% require more than 20 outpatient sessions yearly. Interestingly, those who require more than 20 visits consume over 50% of the total number of visits (Chart 2). Managed care energies can best be focused at that portion of consumers using the most visits because they represent the largest percentage of expenditures. The reason I used CHAMPUS data is because I think CHAMPUS represents one of the highest risk populations, as well as a benefit design that is not constrained by arbitrary limits for the cost per visit or maximum visits per year or exclusion of nonphysician providers. The data represent the absolute worst case.

CHART 2

Outpatient Mental Health Utilization

Visits	% of Utilizers	% of Visits
1 - 5	46	11
6 - 20	38	37
Over 20	16	52

Next let us look at the difference in utilization between different types of organizations. Health maintenance organizations (HMOs) average about 6-8 outpatient visits per person treated per year. Indemnity plans range from a low of 100 to in excess of 1,000 outpatient encounters per thousand. We have a very difficult time calculating the average number of visits, since most claim systems cannot provide that data. Managed care organizations can deliver between 250-350 outpatient encounters per year and actually encourage people to use the service.

For hospital utilization, the HMO's problem is that it uses too few inpatient days. This causes adverse selection to the indemnity plan. If people want mental health and substance abuse treatment and perceive impeded access through the HMOs, they simply select the indemnity plan. The result is selection bias as well as total lack of control. This results in utilization between 120-200 days per thousand per year. Managed mental health companies can appropriately deliver between 60-80 inpatient days per thousand per year. We believe this affords more than adequate access to good health care. Another problem is lengths of stay paralleling benefit design. We literally have providers who call us to certify care and ask how many days of benefit are available. Then they construct a treatment plan which maximizes that benefit. Not only is this wasteful, but it leaves a patient who may have a problem which requires additional treatment without any benefit to cover that additional treatment. That is a clinical, as well as a financial, disaster.

There are three types of factors which influence utilization. First, there are population factors. Clearly, age and sex factors are different for this area. But we are not sure what they are, and we need your help. We need data bases that tell us not only the segment of the population which uses these benefits, but also how that segment differs from the overall population that is at risk. Location also seems to make a significant difference in utilization. The more providers in an area, the higher the utilization. And then, finally, there are some definite industry characteristics. Some of the industry differences may actually be age and sex differences between industries, but some may also reflect industries that exhibit higher problems. For example, with the restructuring of corporate America and downsizing, there are very high rates of stress within some groups, which result in high rates of mental health and substance abuse utilization.

Second, utilization can be affected by benefits. Covered services, chronic versus acute coverage, and maximum benefit limits all affect utilization. What are the incentives to use outpatient or inpatient care? The impact of managed care provisions are also important. How is it being managed and is it working? The final area is the composition and characteristics of the provider network. These things all influence utilization, and different patterns will result based on them.

I want to give you some sense of the difference in age factors. There is nowhere near the variation between age groups that you see in medical care. It is much more uniform. The medical factors I used as a comparison had three decimal positions. Nobody in mental health is even remotely at that level of accuracy. Also, I am not confident in the numbers I use. This is an area in which we need and want your help. Help us develop age/sex factors that we can use in pricing because they do not exist today.

Using prior experience for pricing is a joke because of inaccuracies in the claim data. For example, one large insurer sent us data with categories for mental and for nervous disorders. It has been unable to distinguish what goes into each category! Another company paid alcohol and chemical dependency claims under the medical category (rather than substance abuse) because there was a mandated benefit that these be reimbursed the same as medical care. Another large insurer gave us a claims run showing it spent 30% of its mental health care on surgeons. The data problems go on and on. Data are very difficult to get; they are of highly questionable accuracy, and they are almost uniformly incomplete. As a general rule, whatever you think you are spending, you are spending more. While you think you do not cover marriage, family and child counselling, let me promise you that you do. It is coded as depression, and your claims people pay it. While you think you do not cover nonphysicians, you do because those people are simply billing under a physician tax ID number. While you think you only pay 50% for mental health care, you are in fact paying 80% because ICD9 codes are used which will go through as a medical benefit, as your claims system does not identify physicians by specialty. I strongly counsel you to look at what is really happening in your claims operations.

We have a very difficult time establishing trends in pricing for unit cost and utilization frequency because both supply and demand factors are influencing them. There are three things to consider in pricing with regard to benefit design. First, a moral hazard is introduced if benefits are enhanced. This may encourage utilization by people who

might not previously have had access to service. Second is the primary care practitioner role. The primary care practitioners are almost uniformly incompetent in mental health care. They prescribe medications that are in the wrong dosage and the wrong medication for the problem. They are not able to identify problems and make appropriate referrals. If you work in primary care managed care systems, you may be defeating some of your objectives. Preexisting conditions are also an interesting issue. It is very difficult to adjudicate a claim on a preexisting mental health or chemical dependency condition. The last two pricing factors are underwriting and actuarial standards. Issues such as underwriting participation requirements and selection bias with multiple-plan offerings must be considered. Finally, we need to develop the actuarial factors for age, sex, industry and experience.

Employers are requesting that insurers price their group on a carve-out basis. This is difficult to do because of the very low number of users and the very high cost of treating a small number of those users. The critical mass necessary for the group's experience to attain credibility is much, much larger than it would be for the overall medical plan. You cannot go to a 500 employee, self-funded employer and accurately predict the mental health/substance abuse utilization. The standard deviations are dramatically greater than they are for medical care, and that has a major impact on pricing. There are a couple of strategies. One is to reduce the incidence and severity by requiring preemployment drug testing. This should reduce the number of people going into the system who need substance abuse treatment. Or, you can use the traditional approach of restricting covered services or imposing benefit limitations. You can reduce provider costs through discounts. The problem, of course, is whether those discount providers then simply increase the frequency of services they provide in order to offset the discount. The long-term, best solution is to improve treatment outcome. In the interim we can manage care because I think that will lead to improved treatment outcome.

Managed health care is composed of seven components (Chart 3). The components are the same as those for general medical care. The difference is in applying them to the unique circumstances of mental health care.

CHART 3

Managed Health Care

- Benefit design
- Provider network
- Case management
- Quality assurance
- Training and education
- Claims adjudication
- Reporting

Sandra will talk about benefit design which is probably the foremost thing that can be done. But I caution you: do not change benefits unless you impose managed care, or you will get the worst of both worlds.

Provider network development makes a great deal of difference as John has already described.

You need to go beyond utilization review and into case management. Let me distinguish the difference. Current utilization review is basically diagnostic-specific, length-of-stay monitoring. The length of stay is based on the PAS 50th percentile length of stay for a given age, sex and diagnosis. This will not work in mental health care since the diagnosis is not certain and the treatment reflected in the PAS standards is an artifact of the benefit designs that previously existed. PAS is the national standard by diagnosis for all the hospital admissions and is published by the Commission on Professional Activities. The effect of using PAS for utilization review is to collapse the standard deviation. In the beginning, there was a wide variation in length of stay because people were not targeting particular rates. Once the average is established, the range collapses. This process works well when the mean has had some relationship to clinical need. It does not work when the mean was based on maximizing covered benefits. Therefore, it is no surprise that all the lengths of stay for mental health are 28 days.

Quality assurance means to critically review the treatment. Outcome and the ability to intervene in the treatment is the most significant factor in reducing long-term cost.

An important factor in managed health care is training and education. The best benefit design in the world is worthless if the consumers do not understand it. This is a problem in all of managed health care, but the HMOs are light years ahead of the indemnity plans in recognizing the need for training and education.

Claims adjudication is a problem since most carriers do not understand the DSM3R coding system mental health providers use. Claims are coded as DSM3R (which as the same number of digits as ICD9), but the claim systems capture it as ICD9. While there are not a lot of differences in the coding system, some differences are substantive.

Experience reporting is very important in managed care. Employers will no longer tolerate an environment with inadequate data from any carrier or vendor.

MS. SANDRA M. HITTMAN: Being a nurse, I need to address the issue about the difference in psychiatric hospital costs in Philadelphia and Houston. Nurses in Texas are paid the lowest rate in the nation. Room and board charges usually reflect the nurses wage rates. Also, services included in the normal room and board charges vary from area to area. Analyses by health care coalitions in the Dallas and Houston area found ancillary charges between 69-89% above expected norms, while room and board charges were 25-29% below norms. Although the room and board charges are less, the extra cost of ancillary charges makes up some of the difference.

I want to mention two other points before I get into the benefit design. Our program currently covers over 4.5 million lives, and most cases have 5,000 or more employees. In most plans the spread is fairly equal between dependents, spouses and employees using the mental health benefit. However, although dependents have about a 30% hospitalization rate, they consume between 40-50% of the dollars within that plan. When underwriting a group, it is important to look at the dependent percentage of the group.

Groups with more single coverage and less dependent coverage have costs for psychiatric and substance abuse per employee significantly less than other populations.

The only numerical part of my presentation is the following equation: total cost equals unit price times units used. A benefit plan can attempt to control one of these factors, but unless the whole formula is addressed, there will still be problems. And, if you just control costs without looking at other pieces, there will be a significant negative impact on quality.

The vast majority of people use inpatient care, and all of the other avenues of treatment are blocked. The geographic location of the employee base is very important with regard to cost. Generally speaking, Florida, California and Texas have some of the highest costs per employee. This is more a reflection of the certificate of need process than mental health issues. Four or five years ago in Texas there were no alternate treatment facilities available for mental health. You were either admitted or you went once a week to an outpatient therapist. Four years ago the State of Texas passed a law allowing plans to extra-contractually substitute two days of day hospital for one day of inpatient. Miraculously, four years ago, day hospital programs started in Texas. In states that traditionally have higher funding for public mental health services, alternate treatment facilities usage is much greater. Indiana, in particular, has a state mental health tax. Indiana statistics indicate the utilization control from such a program. If the location is the East Chicago area of Indiana, there will probably be some mix adjusted by industry. Several variables impact utilization, so care must be taken in applying factors without understanding the implication of other underlying factors.

With regard to plan design, I will identify some general areas for discussion points. These are geared to both an employer (whose concerns are employee relations and instituting a smooth plan) and an actuarial viewpoint. The summary plan descriptions (SPDs) should have a clear statement requiring medical, psychological necessity since it is difficult to institute a program without tools to support your plan.

Second, there should be a clear statement for denial of custodial care. Traditionally, plans deny payment to nursing homes and other areas, but there is a significant impact in psychiatric treatment. Some people are chronically ill and will periodically need rehospitalization. The goal is not to avoid all admissions, but to reduce the length of stay for each admission, stabilize patients and get them out of the hospital. So, the custodial care piece is very important, including the definition of what is custodial care.

A plan should have a clear precertification and case management statement. A misconception about psychiatric precertification failure exists. There is a belief that most admissions are missed since they are coded as emergency. That is true. However, the majority of patients with "emergency admissions" called the hospital beforehand, talked to a provider and were given an appointment to come in for an evaluation. When their insurance was reviewed, it was identified that they had an emergency and required admission. But most of those "emergency admissions" occur between 8 a.m.-5 p.m. and do not come through an emergency room or a general hospital.

Marketing in the psychiatric and substance abuse industry is a fine science. There are telephone indicators to determine the number of telephone responses every time a telephone or radio ad is run. The providers can then effectively place their advertisements at the right time and place. In psychiatry, most people self-refer to the highest level. None of us can show up at a general hospital and say, "Put me in intensive care, I think I need to be here." In psychiatry you can walk into any psychiatric or substance abuse treatment facility or general hospital with a psychiatric unit and request admission. And, after a careful review of your insurance plan, you will have consensus on that referral.

The plan design should offer a resource to employees and beneficiaries to help identify treatment options. The requirement for precertification and case management is extremely important. A good psychiatric managed care plan manages beneficiaries' expectations. If the patient is captured by a facility with questionable treatment approaches, the patient's expectations will be managed by the facility. Often a patient is told that if he does not stay for x days, no results can be guaranteed. When you try to manage that care, you automatically encounter many difficulties.

The next point overlaps with John's area. Companies should have a statement within their SPD saying how court-ordered treatment is handled. Most states are finding that the cost for handling dependents within the juvenile justice system is outside their budget, so they have tried to have business pay for that by mandating treatment in the health plan. In fact, very few of those cases really have medical necessity for the level of care that is mandated. Hiding this in an SPD is not effective. To avoid a backlash, the employer needs to discuss this using case examples. It is a good idea to bring it out in the open.

The next item discusses who should provide mental health care. We recommend the following professionals be reimbursed within the plan: Masters level social workers, Masters level psychiatric nurses, Ph.D. psychologists and psychiatrists. There are a large number of providers who sign insurance forms for the staff who work for them. Your plan may pay psychiatrist rates for services that are actually performed by a social worker or a psychiatric nurse who charge only $50-60 per session. But the insurance plan pays $120-150 because it mandates psychiatrist services. The difference is overhead for the psychiatrist to cover having these professionals report to him.

Company specific requirements for covered providers may exist. Particularly with large employers, sensitivity to their own unique culture or needs must be included. Two of the groups we work with are large church groups, the Episcopal Church and the Presbyterian Church. Obviously, these groups believe pastoral counselling is important and should be paid under the medical plan.

When networks were initially set up, there was just a straight percentage break (e.g., 80% in network, 50% out of network). It did not take very long for insurance claim systems, based on Health insurance Association of America (HIAA) data, to pay usual and customary for that particular area. For example, assume the negotiated PPO rate for psychiatrists was $80 and out-of-network benefit was 50% of the HIAA rate. Gradually, the HIAA rates became $160, so that the 50% benefit for out-of-network

resulted in the same dollar amount reimbursement. In many cases people were actually reimbursed at a higher rate out-of-network because there was not a control for having the out-of-network payment tied to the in-network payment. The out-of-network rate should be tied to the in-network price, not the HIAA data.

Another area that ties into network systems is that the out-of-pocket limit preferably should not apply to the out-of-system coverage. If this is not done, providers may waive their fees for the out-of-pocket limit, which is fairly marginal at $1,000-3,000. If an adolescent was to be treated for 45-60 days, the revenues produced would be well in excess of $20,000. The providers would be more than happy to waive $3,000 for the guaranteed filling of that bed.

All care, even out-of-network care, should be subject to medical necessity determinations. The effort of instituting a managed care program is to address quality. The goal is to use the limited resources and money in the most efficient manner.

We strongly recommend in the benefit design not stating the location of treatment for substance abuse care. This is more an employee relations issue than a financial issue. Research has not shown that inpatient care for substance abuse is any more effective than outpatient. But if the plan provides one inpatient treatment episode per lifetime and you use a managed care program to refer people to alternate levels of care, the employee has a sense of entitlement. He may also set himself up to fail in an outpatient treatment setting because he feels he can always fall back on inpatient treatment. Then it becomes a clinical issue, as well as an employee relations issue.

In most mental health plans 1-5% of all employees and beneficiaries consume most of the mental health coverage under a traditional plan that pays just for inpatient care. For many employers, 1-5% of the employees account for 15-25% of the total health care dollars for psychiatric and substance abuse treatment. What we try to do is increase that dollar availability to a large number of employees in other settings.

I have prepared on evaluating utilization review statistics. I have some concerns about the quality of data and how people use it. For example, days per thousand is such an important element. But within a six-month period, employers can change how they calculate the total number of beneficiaries they have. An adjustment by 50% of that factor can have an impact on days and admissions per thousand even though absolutely nothing was done in the plan.

MS. TRYGSTAD: We have a couple of minutes if anyone would like to ask any of the panelists a question.

MR. DAVID R. NELSON: What would be a good mental health benefit plan design?

MR. HILL: Some common characteristics exist. First, it should be comprehensive. It should cover a full spectrum of the levels of care and the providers of care. Sandra gave you some good ideas about what practitioners should be covered and what kinds of treatment programs and facilities should be covered. Second, there should be an adequate benefit to cover the vast majority of the people. My estimate would be

somewhere between $1,500-2,500 a year for outpatient, perhaps $15,000-20,000 a year for inpatient expenses, and probably between $50,000-100,000 lifetime. There should be the flexibility to either substitute between levels of care or use dollar aggregates. In other words, if there are day limits, allow for the substitution of partial hospitalization. Third, there should be incentives to use the network, and those incentives should be more substantial than currently in place today. A 25-30% coinsurance differential would be enough. Fourth, there should be the requirements for prior certification and case management. Fifth, outpatient care should probably be more generously reimbursed than inpatient care because those benefit design features will then reinforce the case management process. Finally, I agree with Sandra. These one-per-lifetime chemical dependency benefit limitations are very constraining. Two is probably adequate, and three would be the more desirable.

MS. HITTMAN: I have a concern with limiting the dollar amount too harshly. In an ideal benefit design it is important to know who you are covering. If you primarily deal with small to medium size employers, there are probably financial limitations. But there are many people who will hit the per-year limit and if they cannot go into the lifetime limit, they will not be served. For example, assume you treat someone who has reached the $15,000 yearly limit. But the managed care firm feels that if another $3,000 or $5,000 could be spent out of that employee's lifetime limit, it would be more cost effective than having that person come back next year. You must be able to offer the full scope of treatment when it is necessary. Ideally, an EPO is the best environment because you can guarantee the quality and hold providers accountable. With regard to substance abuse, I think that detoxification, generally speaking, should be treated more as a medical/surgical benefit. Many states require substance abuse or alcoholism to be treated the same as any other illness. Generally, this is applied simply to the medical/surgical part. From a medical necessity and appropriateness of treatment standpoint, there is very little research to show that more than two rehabilitation episodes per lifetime are ever appropriate. Rehabilitation is primarily education, and there is only so many times you can do that.

MR. FRITZ: Consideration might be given to varying the reimbursement for the outpatient setting depending on number of visits.