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## Session 92PD
## Mental Health Insurance Parity

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**Moderator:** STEPHEN P. MELEK
**Speaker:** STEPHEN P. MELEK
**Recorder:** STEPHEN P. MELEK

*This session looks at the Mental Health Parity Act of 1996 and its implementation to this point. The speaker discusses other federal parity activities and individual state parity reforms. Issues examined include pricing, plan design, and implementation of products modified to comply with these laws.*

**Mr. Stephen P. Melek:** I will explore some of the arguments for and against mental health parity. I'm with Milliman & Robertson (M&R) in the Denver office. I've been there for about eight years and have been involved with behavioral health care issues as a consulting actuary for about the last five or six years, dating back to the Health Security Act when the Clintons started pursuing their health care reform efforts. That was the ideal time for the mental health industry to start promoting mental health parity, or something in between very discriminatory benefits and full parity benefits.

I want to present a case study about the utilization and cost impact on a large group where full parity was implemented as well as some issues relevant to primary care and behavioral care integration, which is one of the other up-and-coming items in the behavioral health care industry. Because some of these issues are somewhat controversial, it might be useful to have a quasi-workshop at the end of this session for volunteer positions on different cost and regulatory issues from those of you who have been involved.

In the early 1990s, mental health parity was not an issue and the reason really wasn't cost. In the 1980s and earlier, mental health care cost a lot of money, increasing rapidly for many years. Then the managed behavioral health-care industry blossomed. Table 1 shows the percentage of the U.S. population enrolled in managed behavioral health care organizations (MBHOs), as well as the

percentage that are enrolled in risk-based or capitated MBHOs. This would include Medicare, Medicaid, commercial, etc. These statistics are from the American Managed Behavioral Health Care Association (AMBHA), whose member organizations cover nearly 100 million lives. From 1993–1996, the percentage that was capitated grew from about one out of every three to one out of every two. If you were to update this for 1998 statistics, my projection is that about two-thirds of the U.S. population will be in a managed care organization and more than half of them probably will be in a risk-based or capitated plan.

TABLE 1
MBHO ENROLLMENT RISE

| | 1993 | 1994 | 1995 | 1996 |
|---|---|---|---|---|
| Percentage of U.S. population enrolled in MBHO | 41.2 | 46.2 | 49.9 | 57.1 |
| Percentage of U.S. population enrolled in risk-based or capitated MBHO | 13.6 | 20.5 | 21.8 | 27.4 |

Table 2 lists some of our data on utilization and cost trends during the 1990s. If you back up into the early 1990s you probably had per-member-per-month (PMPM) cost to health plans of at least $6, if not greater. I would consider that to be a relatively unmanaged delivery system or loosely managed system. It's hard to describe anything as unmanaged nowadays because almost everybody has some sort of preadmission certification, hospital auditing, or at least some basic concepts of managing care. Inpatient days have gone down without substantially addressing an aggressively managed approach; they've been cut in half over the last five years on the inpatient side from more than 100 days per 1,000 in 1994 to about 50 in 1998. This is, again, a loosely managed scenario. Outpatient visits are fairly flat. I think that's partially a result of the inpatient being diverted to outpatient treatments and the use of protocols. If you set up a reasonable cost scenario with an inpatient day discounted to about $500 per diem and outpatient visits at about $75, plus a reasonable set of copays, you can see how much the cost of care has dropped. This is, of course, without administration, which went from about $5 in 1994 to just a tad over $3 in 1998. When costs start getting that low, you start getting a lot more promotion for the lower cost of parity, and, if you start managing this, you can get down into the $2 or even the low $1 range, depending on how aggressively you manage it.

When you get down here, of course this does not address some of the access and quality issues and that's part of the knock on these MBHOs. I will try my best not to name names and offend anybody, but some of the organizations have been bashed in the industry by some of the mental health advocates as to problems with access, quality, people committing suicide because they were denied access to inpatient admission. All the horror stories essentially suggest that you can't deliver quality

managed behavioral health care for $1.00 or $1.25, even with some substantial copays.

TABLE 2
UTILIZATION AND COSTS NATIONAL-COMMERICAL

| | Loosely Managed | | | | | Moderately Managed | Well Managed |
|---|---|---|---|---|---|---|---|
| | 1994 | 1995 | 1996 | 1997 | 1998 | 1998 | 1998 |
| IP admits | 6.4 | 6.8 | 6.8 | 6.8 | 6.6 | 4.6 | 2.6 |
| ALOS | 16.1 | 14.9 | 14.4 | 7.6 | 7.6 | 6.6 | 4.0 |
| IP days/1,000 | 103 | 101 | 98 | 52 | 50 | 30 | 10.5 |
| OP visits/1,000 | 336 | 331 | 340 | 340 | 349 | 280 | 215 |
| PMPM* | $4.83 | $4.75 | $4.68 | $3.15 | $3.12 | $2.17 | $1.25 |

*Using IP cost/day of $500 and OP cost/visit of $75; IP copay @ $100/day; OP copay @ $25/day

I want to give you an idea about how MBHOs would typically price some of their products (see Table 3). This is not an actuarial approach, but I think even actuaries can learn from some other financial buildups of their PMPM costs. The way that they would go about it if they weren't using an actuary or they didn't have an actuary of their own is they would look at a population that they would be covering. In this scenario there were 100,000 covered members and the MBHO would price out the different types of professionals needed to service those members. The MBHO overhead components are composed of intake therapists and two full-time equivalents, clerical intake people, utilization management (UM) nurses with an M.D. backup for triaging, claims processors and some sort of pro rata share for general management, contract management, and provider relations. They can have salaries, benefits, and everything loaded in that. They're just putting dollar amounts into the different buildups to serve this 100,000 population and then some allocation or leasing for management information systems, and supplies, rent, and quality management. There's a bigger and bigger cost issue involved for MBHOs on quality concerns and AMBA has come up with Performance Measures for Managed Behavioral Healthcare Programs (PERMS), is quality-focused. Measurement devices within PERMS prove that you're doing a good job from a quality and access perspective—how quickly you respond to the 800 numbers and those kinds of things.

In addition, MBHOs would go into their utilization and cost-of-care components and put together their own estimate of mental health and chemical dependency facility costs (see Table 4). In this scenario, this would include some sort of the acute alternatives on an equivalent inpatient basis. By that I mean if they're using residential facilities or intensive outpatient programs, or partial hospital programs, they have developed utilization expectations of those on an acute inpatient basis. If there were a 2:1 trade off or a 3:1 trade-off, they'd look at the unit cost and build up an acute inpatient equivalent. They have inpatient professional services and

professional outpatient consults, perhaps specialists for eating disorders or those kinds of things, in case they have to go outside of their own networks for certain types of services. The overhead carryover is their profit and contingency load. They attempt to build up their PMPM costs bidding out commercial rates, Medicaid rates, etc. In this case the cost turned out to be $2.75 PMPM.

TABLE 3
MBHO OVERHEAD COMPONENTS

| Component | Cost |
|---|---|
| Intake therapist, 2.0 FTE* | $85,000 |
| Intake clerical, 1.0 FTE* | 25,000 |
| UM nurse, 1.5 FTE + .2 M.D. backup | 100,000 |
| Claims processing clerk, 1.5 FTE | 40,000 |
| General management pro rata share | 150,000 |
| Contract management/provider | 90,000 |
| relations, 1.5 FTE | 150,000 |
| MIS lease, supplies, rent, etc. | 60,000 |
| Quality management | |
| **Total overhead costs** | **$700,000** |

*All staff costs include benefits

TABLE 4
MBHO COST OF CARE PRICING (100,000 MEMBERS)

| | | |
|---|---|---|
| MH facility | 15 days @ $450 | $675.00 |
| CD facility | 6.5 days @ $450 | 292.50 |
| MH facility—professional | | 155.00 |
| | | 62.50 |
| CD facility—professional | 240 therapies @ ($65–$25 copay) | 960.00 |
| | 70 med mgt @ ($55–$25 copay) | 210.00 |
| Outpatient professional | | 30.00 |
| | | 700.00 |
| Consultations | | |
| Overhead | | |
| Profit/contingency load | | $3,085.00 |
| | | 215.00 |
| Total services cost | | $3,300.00 |

It's interesting how some MBHOs go about developing their utilization and costs. Even though they have grown to a tremendous size, several of them started out as mom-and-pop psychiatric shops. They decided it would be a good idea to build a network and build some expertise to be able to take risk contracts, so they sat around a room and thought about utilization assumptions. Once they had some of their own experience with different benefit designs, they would intuitively bounce ideas off the clinicians in the room and make a determination, maybe with the chief financial officer, of what their utilization assumptions were going to be. There was not a full-blown scientific actuarial analysis going on, understandably. Some of them have developed their own expertise. They've gotten a bit fancier as far as

trying to develop the key assumption, which is really utilization. Another key assumption developing is the unit-cost assumption. We'll talk more about the differences in coming up with unit costs as we go further. Many theoretical pricing issues are being explored here behind the setting of the equivalent inpatient utilization assumptions, outpatient assumptions, etc. These aren't always considered, but more MBHOs are realizing the importance of an actuarial or a theoretical approach to pricing some of these risk contracts.

For behavorial health care capitations, there are a number of pricing issues. Benefit design limits and coverage issues need to be explored, especially when it comes to parity. The mental health versus substance abuse component involves trying to consider some of the comorbidity and the potential gaming of diagnoses if you do have a benefit differential between these types of coverages as well as a shift along the continuum of acute inpatient alternatives and the professional service shift as you provide a panel of different types of lower-cost alternatives. Induced demand is one of those grayer issues, although more and more facts are becoming available on the induced demand issue. We'll talk about induced demand related to benefit design differentials and induced demand related to some of the degree of the stigma or the social acceptance that is in place in different parts of the country and how that changes when benefit design changes. Employee assistance programs (EAPs) exist at the front end of some of these managed programs, and the impact of Medicaid has an impact.

In the pricing of parity benefits, about three years ago our firm got involved in some of the federal reform activities, including pricing what it would cost for full-blown behavioral health-care parity. Costs have narrowed down into a 3–4% range, when you consider the various actuarial estimates that have been made, although there are still costs outside of that range and what's important is where you're starting from on a benefit design issue, how well-managed the system is, and what kind of plan you have when you start pricing some of these things.

One of the issues with Medicaid was a cost shift from the public sector to the private sector under parity in commercial coverage. One of the arguments was: If you go with full-blown commercial mental health parity, you're just going to start paying out of a different bucket. Historically, people who had run out of their very limited commercial benefits would end up in the public sector with Medicaid or some other funded uninsured program paying, especially for seriously mentally ill people who ended up in an institution, including emotionally disturbed kids. Somehow they must be cared for. You're just shifting money around. Some of the evidence that's coming out now as mental health parity programs have been implemented and some of the costs have been analyzed and followed, has not strongly supported that issue. The public sector programs are not seeing the kind of

savings or shift into the private sector that some of the arguments were essentially suggesting, so the jury is still out on that. I'd be interested in your own experience and knowledge about that when we get into the question-and-answer section later on.

When you start pricing parity benefits, you're often starting from benefit designs that had inpatient acute day limits per calendar year or per episode or per two calendar years. All kinds of designs are still floating around out there. You don't see many calendar-year dollar or lifetime dollar limits anymore. That was what the Mental Health Parity Act was all about. Maybe some plans haven't hit their new plan years yet or you have small groups or other sorts of preempted plans out there, but those plan designs were essentially eliminated with the Mental Health Parity Act. Let me segue into the Mental Health Parity Act from the typical mental health proponent's perspective.

From an actuarial perspective, you can look at the Mental Health Parity Act and say, "Big deal, so what?" What kind of parity is that? What have plans essentially done to comply with the Mental Health Parity Act? From my standpoint and experience most plans have seen very limited, if any additional cost because all they've done is convert from a dollar limit to a visit and a day limit. They've developed some sort of expected actuarial equivalent and gone from a $1,000-per-year limit to maybe a 10-day or a 15-day inpatient limit and a 20-visit limit So, early on a lot of parity opponents said, "big cost dollars," but when they realized there were ways around this, they essentially achieved cost neutrality through different benefit designs. So there really isn't parity. You might look at it as a loss to the mental health advocates, as if nothing was gained through the Mental Health Parity Act. But the advocates' position is that this is a Bill Murray baby step, if you remember the movie *What About Bob*. It was a baby step for the industry in the right direction. Eventually, they will attempt a much larger step. From a federal perspective, last year they got the Mental Health Parity Act. This year they're sitting on the sidelines watching the states do their thing. There's a lot of state activity out there now. Maybe half of the states have already implemented or are in discussions about an expanded mental health or behavioral health care parity program. Next year the advocates are probably going to say, "See, what all the states are doing; it does make sense." We have some cost dollars out there, so the federal activity will pick up because the advocates will be armed with more information on the cost and utilization impact and the quality issues from a state-by-state program and will probably champion the one or two states that are really doing it well. That's how the activity will pick up again on the federal level.

Anyway, the big parity pricing issues are day and visit limits and coinsurance and copay differences. There are plans that have large copay differentials. You might

have a $10 office visit copay to visit a primary care or nonbehavioral specialist, but a $25 copay to see a behavioral specialist. Instead of the coinsurance being 80/20, it might be 50/50 for behavioral health care. There are plans with maximum benefits allowed for an outpatient treatment service. In other words, they might have a $25 copay, but they'll only pay up to a maximum of, let's say, $50 per outpatient visit. In my opinion, that still qualifies as meeting the Mental Health Parity Act—although you could stretch the argument in the other direction, but it is really not discriminatory from a calendar-year dollar limit. It's providing an open-ended copay of sorts by saying you're only going to pay for up to $50 if you're going to be billed at greater than $75 per visit under my scenario of a $25 copay. Out-of-network use is an important issue. Going back to the early days, some of the managed behavioral health care organizations that didn't do a scientific actuarial pricing approach pooh-poohed the out-of-network utilization scenario. I know a lot of them got bit in the behind because they underestimated the impact of the relationship between the client (insured), and the mental health professional and their willingness to go out-of-network. Whether it was for confidentiality reasons, relationship reasons, the limits inside the network, or a concern about the therapists and the way they managed care, there were lots of reasons for them to continue to stay out-of-network, and the costs were substantial in some cases. If they were still at risk for these out-of-network costs, it became a big dollar element of what insurers were at risk for, and some of them actually went broke just because of the out-of-network risks that they had taken on.

The cost of medications is another benefit design issue. It's in its primitive stages as far as how many behavioral health care firms are responsible for it. Most are not responsible for medications. In Tenncare (Medicaid program in Tennessee), the MBHOs took on the psychotropic and pharmaceutical behavioral risk. It was part of their capitation payments. Interestingly enough, if you didn't expect it, a lot of the prescribing that's done for psychotropic medications are done by primary care doctors. How much control did the managed behavioral health care organizations have over the primary care doctors when they are writing maybe two-thirds or three-quarters of all the psychotropic scripts? Zero. Costs went through the roof, and they started losing big time on all of those costs, so much that Tenncare has finally decided to take the risk back. It decided to cut the capitation rates by, I think, $3 PMPM and the managed firms are much happier now. But this is closing the barn door after everyone's left the barn. You do not want to take risk over utilization management of certain benefits if you don't have substantial control over such utilization.

Everyone knows all about the Mental Health Parity Act by now, applying to group health plans and coverages with 50 or more lives, affecting calendar year and lifetime limits, as of January 1. A 1% cost increase exemption is a retrospective

exemption, and lots of arguments both for and against prospective exemptions. As actuaries, we deal with prospective projections all the time, but here was a victory for the advocates in the industry to require the retrospective proof of 1% cost increases. In some states the cost has been substantially lower than a 1% cost exemption. Has anyone been involved yet with the proof of an exemption that it's going to be more than 1% for certain plans? There is a show of hands of zero and that's not surprising because that's my experience as well.

There clearly are different stigmas involved with substance abuse versus mental health treatment. It seems that the mental health advocates have made more progress related to the stigma issues and the appropriateness of covering mental health benefits just like any other illness. Substance abuse providers and their advocates also have pointed to the inappropriateness of discrimination, although there is a different stigma between chemical dependency and the type of people who have those kinds of problems. Then again, you see some states that have richer substance abuse benefits as mandates than behavioral health mandates. There is, in my experience, a greater savings potential on the inpatient side for alternatives for substance abuse using alternatives along the full continuum of care than for mental health. There is about a 5:1 cost relativity, although that changes if you aggressively manage it. Comorbidities between mental health and substance abuse tend to be in the 15–20% range.

Here are some samples of achievable discounts and rates from the acute inpatient alternatives: acute inpatient ($400–500, maybe lower), residential ($75–175), partial hospital ($150–200), and integrated outpatient/day treatment ($75–125). Some of these residential rates might be low from your experience. There are rates in the $250 range out there, depending on where you are, what kind of residential sites you have, and the kind of people you're caring for, etc., but the shift depends on available alternatives along the continuum.

From my experience with some of the AMBHA member companies, if the question is, "How much utilization really goes on in the acute inpatient's alternative settings compared to a 100% baseline for all acute inpatient psychiatric hospitals, psychiatric wards, psychiatric units, and general hospitals?" A good median might be somewhere in the 20% range. If you wanted to ask on an equivalent basis, "How much utilization is going into the acute alternatives?" about 20% is being done. Some organizations are more aggressive in these modalities—up in the 50% range, where 50% of the inpatient days are now diverted into these acute alternative settings.

On the professional side, you have the shift from the M.D.s and the psychiatrists to the Ph.D.s, the master's-level social workers (MSWs), and the registered nurses

doing lots of the things that only psychiatrists or maybe the Ph.D. psychologists used to do. There is much more aggressive utilization of group therapies, and quick focus therapies. I don't know if you want to call this an extreme, but in some places in the country you have a psychiatric medical director who's reviewing every single case visit for approval to drive utilization down aggressively.

Table 5 shows some of the discounted cost alternatives. It makes sense to move people from the physicians and the M.D.s down to the Ph.D.s and the social workers. Move them from the 45-50 minute sessions into the briefer sessions, groups, and medical management. How much cost savings are available from a loosely managed "see your psychiatrist or psychologist once a week" to an aggressively managed medication treatment of some of the diagnoses? You might see your psychiatrist for a maintenance visit once every three months.

TABLE 5
DISCOUNTED PROFESSIONAL MENTAL HEALTH SERVICES
BY TYPE OF PROFESSIONAL

| | **MD** | **Ph.D.** | **MSW** |
|---|---|---|---|
| Diagnostic interview | $85–90 | $70–75 | $55–60 |
| Individual therapy (20–30) | $50–60 | $45–55 | $30–40 |
| Individual therapy (45–50) | $65–75 | $55–65 | $40–50 |
| Group therapy | $35 | $30 | $25 |
| Medication management | $40–50 | --- | --- |

How much cost savings are available along the continuum as you go that route—less costly providers, types of therapy, and medication management versus therapy? If you're not aware of the battle that sometimes exists in the industry between the psychiatrist and the psychologist, this would clearly illustrate that. Psychologists are qualified to dispense the medications, so psychiatrists are taking care of their turf and their medication management approach. However, as the higher-cost drugs come into play, to enable more psychiatric intervention, different kinds of therapies from the psychologists might be selected especially when you have a limited benefit. The battle exists for how you use that kind of limited benefit, but, of course, they're all applauding the parity approach because it implies access to unlimited benefits, days, sessions, and drugs, so there's a lot going on when you're trying to price these parity benefits.What about the use of case rates for some professionals? Some managed behavioral programs are aggressively approaching the psychologist or the psychiatrist with case rates that give them $100 per treated individual to take care of a given benefit. This includes the first three sessions and, if there are complications, they'll look at it visit-by-visit afterwards. They might give $200 or $300 to take care of the first eight visits, medication management sessions or whatever it would be. After that it would have to be a severe case to get alternative funding. In some parts of the country, psychologists have jumped on board to maintain their proportion of the market base with some of these

aggressively priced plans and get the $200 and $300 reimbursement rates. Then the clinical issues and the quality issues come into play where the psychologists decide to abandon that arrangement because it's not worth it to them from a clinical perspective to have to tell their clients, "This is your last session because I'm going to go broke if we continue treating you two or three more times." Their average number of visits per client goes from four or five to seven or eight because they can't handle it under the case management and the case rate approach that they've signed onto for the next 12 months. Many issues come into play from a professional and a clinical side.

Induced demand in the degree of health care management comes into play when you start raising benefits from a 10-inpatient day or a 20-outpatient visit to an unlimited benefit, when out-of-pocket costs goes down. Induced demand includes the increase in utilization just because of a benefit change. If I'm going to see a psychologist, for example, for treatment for depression and I have to pay 50% of the benefit, versus having to pay $10, and they're charging me $125 every time I walk in the door, that might induce me to use a few more visits or a lot more visits. This is especially under a parity program or if it's not well-managed, because now instead of being out-of-pocket $50 or $60, I'm only out-of pocket $10. A lot of activity will change when the out-of-pocket costs change that substantially, as well as when you lift the lid off of inpatient days and outpatient visits.

Some of the programs introduce new coverages. V-codes for personal problems, such as attention deficit disorders, and those kinds of things. Other causes enter the picture.

If an EAP exists, that can affect the pricing and cost of the managed behavioral program. There are a lot of potential downline, downstream costs that the managed behavioral firms will incur in a typical behavior health care benefit, so they propose to the employers that are looking at new or expanded EAP programs their ability to save money by solving problems early on, or at least solving some of the minor problems early on. The existence and the design of the delivery of some of these EAP programs is a pricing consideration for actuaries, especially if they're integrated with some of the managed behavioral programs.

Before I get into the case study, I want to segue to an experience I had related to the behavioral health care industry describing the mind-set of this industry. I'm the only actuary in a meeting with 500 behavioral folks. They're very emotional on these issues, but you can understand it. As actuaries, we were told just a few years ago that we had the best job in America. There are never enough of us. We get paid all of this money, we have job security, low-stress environment, and all these great things about our industry. But if you look at it from their perspective, there are too

many of us. Their behavioral health care rates have been discounted heavily. If you look at some of the discounts they've been granting in the industry, the managed behavioral wave has washed over the industry, so they can't do much fee-for-service business or nearly as much as they wanted to, in a lot of places in the country. They've been discriminated against by benefit design and feel like the whole world's against them. If you get up in front of them and start talking about what it costs for them to deliver care, you have to be very careful. Earlier this year one of my colleagues did an analysis for a national center policy research issue, on the high cost of mandated benefits, one of which happened to be mental health parity. The concern was, you keep driving costs up with mandated benefits, and people become uninsured. Employers, especially small ones, drop coverage, or they pass it on to the employee. For every 1–2% increase in mandated benefits costs, how many more individuals become uninsured? Those are solid arguments in a lot of cases.

My colleague was doing an analysis of a set of mandated benefits and the related costs, and the result for mental health care was a 5–10% cost increase. Nothing happened for about six months until it hit the press. Now, as an actuary you're going to ask, "What's behind that 5–10% increase?" But the press doesn't do that. They'll say, "It costs 10% for mental health parity. You can't mandate that because it's way too expensive. Look what will happen to the uninsureds," etc. They didn't even take the 5–10% range. The press doesn't look at the scenario behind the numbers. The scenario was, first you start with no mental health benefits. Is that viable today? No. You start with none and then you go to full parity. Well, that's a pretty big increase in benefits. Second, there are no discounts, so you're paying full scale: $1,000 per inpatient day and $130 per outpatient visit or whatever it happens to be. You're going from no benefits to full benefits without any discounts and it's totally unmanaged. That's the worst of all possible worlds to price what the cost increase would be, but the press doesn't acknowledge that as they hit you with 10%.

My phone started ringing because I was the author of one of the cost estimates that said full parity would be about 3.5%. Very irate people were saying that the world was going to fall apart for mental health care because of this mandated mental health 10% cost report. I literally spent hours on the phone with some of these people trying to justify why 10% was a reasonable cost estimate if you understood its context. I don't know if you've ever had to go before a board of directors or other actuaries or marketing people to try to justify why your cost increase makes sense, but it's a very sensitive issue. My pet peeve is when numbers get thrown onto the table without explanations. If it's anything from a utilization rate to a cost number, as actuaries, we always want to know what's behind the numbers. But a

lot of people run around with numbers, without knowing the context of the number.

Here are some real numbers. I'm going to argue the side of the low-cost impact of mental health parity and then I'll argue the side of the high-cost impact of mental health parity. I'll talk a little bit about some other mental health numbers, and then we'll open it up for questions and comments.

This was a mental health and substance abuse parity case study of Ohio's state employee program and its benefits. Before this program, there were other reports and experiences in the early 1990s that switching to managed behavioral health care would immediately result in cost savings. But before that was implemented in the late 1980s, a lot of employers were experiencing 20% cost increases in alcohol, drug abuse, and mental health costs. If you could achieve cost containment of managed care, the theory was the next challenge would be parity, but the parity debate was fueled by a lot by assumptions. Actuaries were running around making assumptions about what the cost would be, but there wasn't much actual experience back in the early 1990s about what the true costs were.

Ohio always had this desire to have full mental health parity and in its state employee program, they thought they could manage it by just denying access. You put in a primary care gatekeeper and if he or she has control over all the referrals, you can open up (increase) the benefits all you want and they'll just limit the access to benefits. So, the supply of services could render meaningless any mental health parity benefits. They had some control over this by how they worked with the programs in the managed behavioral carve-outs within the state employee program.

Just to give you the history, from 1990 to 1995, the state of Ohio had two different types of plans: an HMO plan and an indemnity plan which had an unheard-of mental health benefit. There were no inside limits for behavioral health care on their indemnity plan. It was carved out, but still had no inside limits or deductibles. With copays, they had the full continuum of services covered. All care was managed. It was carved out. The indemnity plan in 1990 was carved out by Ohio Biodyne, which later became Medco, then Merit and then Magellan. That's a very good illustration of the gobble up effect on MBHOs. The state's HMO plans did have a variety of different designs, but a common one was 30 inpatient days and 30 outpatient visits. The HMOs themselves had responsibility for the behavioral benefits. It wasn't carved out uniformly to somewhere like Ohio Biodyne as a full risk contract on the indemnity plans. There were referrals through 800 numbers, etc. so that you knew in the first five to six years of this program what the plan designs looked like.

Then, starting in 1995, Ohio decided through a bid process to carve all of it out, the HMO business as well, and they went to U.S. Behavioral Health (USBH), which has since become United Behavioral Health. All plans went to the higher benefit levels, so the indemnity levels kept their benefits, and the HMO levels went over to the indemnity level of benefits. V-codes were covered uniformly. Midway they started becoming covered under the indemnity Biodyne contract. Attention deficit disorders became covered where historically only parental counseling, not the kid's part, was covered. They were precertifying five outpatient visits at a time. Under the Biodyne carve-out it was three. Interestingly, in 1998 they upped that to ten because of the success of the program, which we'll look at in a second. Again, it was a full risk contract. They also instituted performance guarantees about utilization levels. We'll talk about that.

Here are some unit cost assumptions, net of copays, that they experienced in 1996 and 1997. They were at $470 per inpatient day, $250 per residential day, $180 per intensive outpatient day, and $55 per outpatient visit. Table 6 has some interesting utilization statistics and cost statistics from 1989 to 1996. Full behavioral carve-out kicked in during 1990 on the indemnity side. It was unmanaged in 1989, so the first year it was managed was 1990, and the inpatient days dropped by 75%. You probably have seen that in your own organizations or somewhere if you're familiar with the impact of managed mental health care. Outpatient visits dropped about 40% with the implementation of management. They had a small increase in total benefits, but this involves going to full parity while managing this stuff.

TABLE 6
UTILIZATION AND COST TRENDS—INDEMNITY PLAN CARVE OUTS

| | **Unmanaged Care** | **Biodyne** | | | | | **USBH** | |
|---|---|---|---|---|---|---|---|---|
| | **1989** | **1990** | **1991** | **1992** | **1993** | **1994** | **1995** | **1996** |
| IP days/1,000 | 204 | 51.8 | 48.2 | 44.0 | 40.7 | 32.1 | 24.7 | 20.1 |
| Res. Days/1,000 | -- | -- | -- | -- | -- | -- | 19.1 | 9.7 |
| IOP days/1,000 | -- | 10.9 | 12.0 | 28.4 | 44.8 | 40.2 | 33.1 | 34.4 |
| OP visits/1,000 | 1060 | 614 | 555 | 534 | 534 | 507 | 449 | 476 |
| PMPM cost | NA | NA | $5.39 | $6.00 | $6.53 | NA | $4.03 | $3.64 |

While it's not noted here, access went up from about 5% of the population being covered in 1989 to somewhere between 7% and 9% during the managed approach. Another trend to observe is once it was managed by Biodyne and then USBH in 1995 and 1996, inpatient acute utilization continued to go down by another 60%, from the low 50s down to 20 days per 1,000. The acute alternatives started in 1990. You can see that the residential days are missing for the first five years of that. It could have been unavailable. It also could be that it was being coded as an inpatient and intensive outpatient days.

That's one of the things that I continue to see when I get involved with some of the different insurance companies and other firms that have behavioral-health care data: People often don't know where their data really is. It may not be an important issue to you, but you need to know where your alternative to acute inpatient days are being reported in your reporting systems. Usually outpatient visits are standard and you have current procedural terminology (CPT) codes to cover them, but these other services have their own codes. If you want to get the history, you may not be able to get clean numbers. Outpatient data has stabilized, but acute inpatient alternatives did increase with the drop in acute inpatient days.

The cost issue is an interesting topic. During the early 1990s, and again this was managed full parity, costs went from the $5 to the $6 range to the high $3 and low $4 in 1995 and 1996 as it became better managed and the market became more mature. One of the arguments on the Biodyne side was that they were not sure this was really a cost of care set of numbers that was being reported. These are full risk contracts. They were being capitated, but if they properly identified utilization and costs of what they were paying out for all their services, which supposedly is truly being reported under the USBH data—the $3.64 and the $4.03—they weren't quite sure that the numbers being reported during 1991–1993 weren't actuarial assumptions. But assuming they are nearly correct, I think this is quite an argument about the potential to manage down even lower costs of full parity benefits.

On the HMO side, Table 7 presents a scenario where benefits were increased from somewhat restrictive HMO benefits that were managed to unrestrictive benefits from 1993–1995/1996. Here again, they were reporting the true costs of managing the health care. What's interesting is the increase in the first year when it shifted over to USBH and the first year it shifted over to full parity. The inpatient went down, but the acute alternatives went up. Outpatient benefits went up substantially. But when you look at the trend from 1995 to 1996, the net effect is that they went to full parity and the cost didn't change. Initially, they argued that there was a pent-up demand, the induced demand effect of people utilizing the richer benefits, additional covered services, and additional covered diagnoses. But after a year of maturity and managing, the cost is the same, so there's clearly an argument in favor of the low cost nature of managed mental health parity benefits.

TABLE 7
MENTAL HEALTH AND SUBSTANCE ABUSE PARITY CASE STUDY OF OHIO'S STATE EMPLOYEE PROGRAM—UTILIZATION AND COST TRENDS—HMO MEMBERS

| | HMOs | USBH | |
|---|---|---|---|
| | 1993 | 1995 | 1996 |
| IP days/1,000 | 32.6 | 27.3 | 16.8 |
| Res. days.1,000 | -- | 20.0 | 9.6 |
| IOP days/1,000 | 14.5 | 49.3 | 38.8 |
| OP visits/1,000 | 368 | 542 | 547 |
| PMPM Cost | $3.66 | $4.66 | $3.64 |

As Table 8 reflects, quality was an issue, because one way to look at quality is contractual standards and performance guarantees. Ohio didn't want their state employees being denied care and access. That's one of the knocks against these managed behavioral companies, so Ohio had standards. A minimum had to be utilized—minimum inpatient days; minimum outpatient visits; minimum intermediate services. Other than being a little bit low on the inpatient side, USBH's achieved results were above all of the minimum requirements in the second year of the contract.

TABLE 8
MENTAL HEALTH AND SUBSTANCE ABUSE PARITY CASE STUDY OF OHIO'S STATE EMPLOYEE PROGRAM—UTILIZATION LEVELS VS. PERFORMANCE GUARANTEES

| | Contractual standards | USBH | |
|---|---|---|---|
| | | 1995 | 1996 |
| IP days | 25 | 26.2 | 18.3 |
| Min OP days | 500 | 503 | 579 |
| Min intermed. serv. | 40 | 62.2 | 46.7 |

What the state of Ohio, and other organizations have learned is the sophistication in the management systems of some of the managed behavioral systems compared to the medical systems. When it comes to outreach, concurrent review and disease management are high, but from a technological standpoint it's low. Pharmaceutical therapies and the cost of new drugs are increasing quite rapidly. Interestingly, one of the things that people are still arguing about is the cost of the drug treatments outside this program. You can argue that full parity didn't really increase behavioral benefits, but if the psychotropic drugs are outside the costs, what about how much they might have increased? That's an interesting question and one I don't have an answer for from these numbers, although I'd be interested in what those numbers have looked like too.

One of the other arguments for mental health parity is that over time, with the aging of America, you're going to have people aging out of mental health parity because the high-cost groups are in their 30s and 40s. As they get into their 50s and 60s, by nature, utilization goes down.

Collaboration between primary care and mental health care is a trend these days in the clinical settings. Why collaborate and integrate the delivery? There's a high level of behavioral health care being treated in primary care settings compared to mental health settings. The high level of comorbidity is argued between psychological illnesses and chronic physical diseases. There's a low level of patient compliance when it comes to primary care referrals to mental health specialists. Some different statistics that are thrown about in the industry are that as much as 75% of all medical visits have no confirmable medical or biological diagnosis. That 15–25% of patients seeking primary care help of some kind have an anxiety or depressive disorder, and that only 5–6% of all covered lives in an HMO setting access mental health coverages. Half or more than half of primary behavioral care is done in primary medical care settings. Two-thirds of all drug medications for mental health conditions are written by primary care or other non-psychiatric physicians.

Common symptoms in primary care medicine visits are: chest pain, fatigue, dizziness, headache, back pain, insomnia, numbness, abdominal pain, etc. Some other data from the University of Wisconsin School of Medicine are unexplained physical symptoms:

Headaches:
- 48% were unexplained
- 53% were linked to depression
- 44% were linked to anxiety disorders

Stomach Pain:
- 46% of primary care visits unexplained
- 66% linked to depression
- 50% linked to anxiety

Back pain:
- 30% unexplained
- 53% of them linked to depression
- 40% linked to anxiety disorders, etc.

This is statistical, clinical support to treating or at least linking the diagnosis and treatment and the integration of mental health care in primary care settings. Some other comorbidities of psychological illness and chronic physical diseases include arthritis, cancer, diabetes, heart disease, hypertension, chronic lung disease, and neurological disorders.

Because of the economic costs of depression—the treatment costs, the mortality costs from lost earnings from suicide, and the morbidity costs from the employer perspective, employers are starting to open their eyes more widely at the morbidity costs—caused by absenteeism at work or productivity reductions because of mental

health and behavioral conditions and how these compare to some other numbers that are more in the public eye. One of the arguments from the behavioral community, which I think has actuarial support if it can be proved, and that's a big if, is medical cost offsets related to behavioral health care interventions. If you can save money on the medical side by expanding or increasing access and/or behavioral benefits, thereby increasing behavioral wellness, there is a logical support for cost offsets.

Table 9 shows some of the numbers that one organization was able to report when it fully integrated primary care treatment and behavioral care treatment. Visits for minor medical illnesses went down by 35%. Surgical lengths-of-stay dropped. You might ask, "Where is that correlation? Why would a surgical inpatient admission have a lower length of stay because of behavioral interventions?" The correlation has to do with anxiety about the surgery. People become quite anxious and have longer lengths of stay, depression related to surgery, use of pharmaceutical drugs for pain, or whatever else is going on because of major surgeries. Other kinds of interventions are becoming more prevalent in emergency rooms. They're trying to find panic disorder patients the first or second time they visit the emergency room, not the eighth or ninth time that same year; going around the medical inpatient units and trying to diagnose substance abuse disorders in inpatients being treated for related medical conditions; etc.

TABLE 9
MEDICAL COST OFFSET REDUCTIONS ACHIEVED
THROUGH BEHAVIORAL MEDICINE INTERVENTIONS

| Treatment Category | Reduction |
|---|---|
| Total ambulatory care visits | 17% |
| Visits for minor illness | 35% |
| Pediatric acute illness visits | 25% |
| Office visits—acute asthma | 49% |
| Office visits—arthritic patients | 40% |
| ALOS—surgical IP | 1.5 days |
| C-section rates | 56% |
| Epidural anesthesia, labor/delivery | 85% |

Lastly, let's argue about the high cost of mental health parity. An interesting state that I've been recently exposed to is the state of Arkansas. The state of Arkansas is interesting because it is very loosely managed. They have had very, very limited benefits for their programs and it's not uncommon to have very tight inpatient days and outpatient visits. To lift the lid off a state where you have very limited benefits and a very unmanaged scenario to go to a full mandated benefit where the provider community might be resistant to managed care and discounts, creates the potential for much higher cost than you would see in a very mature managed care marketplace. That's where the insurance companies and those that are very concerned about the high cost of parity, as back in the 1980s when you managed

mental health by managing benefit design, are today, and lifting the lid off that can really have a much higher cost impact than in other states and other scenarios. So you have people who would argue very strongly against the potential for high cost. Instead of 1–4%, you're doubling that and getting close to 10% or more, and the subsequent impact of uninsureds and other factors that come along down the line.

**Ms. Joan P. Ogden:** First of all, I'd like to register a plea that we stop using the term "discriminatory" with regard to benefit variations. Benefit plans are full of all sorts of variations and limits and simply because a benefit plan has a variation or a limit does not mean it is discriminatory. The mental health professionals have latched onto this as a reason why the evil insurance companies ought to undo what they have done with regard to individuals who suffer from particular illnesses. I think if we stop using the word, we will stop pressing a trigger and start to talk about it in a rational fashion.

In a number of states there are state codes prohibiting panel benefits with regard to mental health services under indemnity coverage or any other panel benefits, so that where you have indemnity coverage you may not have a restricted panel. You can have some sort of prior certification, but for indemnity plans, which are often the selection of small employers and individuals, that presents a very difficult problem in terms of managing utilization, if there was not financial management such as higher copayments. I can report that, in Utah, the shift from Medicaid to the private sector did not occur because Medicaid mental health was being managed from a wait-for-access process. And, as you move more people off of the Medicaid rolls in terms of the managed mental health arena, you simply open up more access for those who are remaining in the Medicaid environment.

**Mr. Melek:** You reminded me of one other condition about Arkansas. There was an "any-willing-provider" environment, and that certainly adds an interesting twist to what might happen with parity benefits in that kind of a scenario.

**Ms. Leslie F. Peters:** I guess your case study for the state of Ohio in terms of the level of managed care provided a logical transfer of inpatient days to other optional settings, like the residential or intensive outpatient. However, in Table 2 the well-managed column shows reductions in every category for inpatient and outpatient. It seems as if that is probably indicative of just managed costs and denial of care as opposed to actually providing better care. Would you agree with that? Can you describe what is different in the well-managed model versus the loosely managed or moderately managed other than denial of care?

**Mr. Melek:** Well, first of all, I should say that the table did not have, as a piece, the acute inpatient alternatives. I neglected to say that the table included only the acute

inpatient days and outpatient visits, and there is not that slice for acute IP alternatives in that particular table.

**Ms. Peters**: Okay, that would describe a lot.

**Mr. Melek:** That would describe some of it, but your point can be applied to the medical side as well if we have a table detailing inpatient admits for different medical-surgical conditions between a very loosely managed delivery system and a very tightly managed system.

**Ms. Peters**: On the medical side, though, you could argue that there's a certain amount of treatment that goes on and the rest of the time is just recovery in the inpatient setting, whereas on the mental health side, correct me if I'm wrong, I assume that there's something actually being done in each of the visits being provided. Maybe that's not true.

**Mr. Melek:** I don't know how I want to answer that one. I think the MBHO's premise is that you can treat stable cases on an outpatient basis, although you don't see outpatient visits being driven down the way you see on the inpatient side. In the old benefit design you had an either/or approach. You either had an outpatient session for 45 minutes with a therapist or a psychiatrist, or, if your condition was serious enough, you were placed in a 24-hour site so you could be observed, medicated, and talked to. You could be stabilized, etc., and there were a lot fewer acute admissions in the acute facilities in the old days. Nowadays with the triaging that goes on, you really have only major conditions being admitted in tightly managed environments—the suicidal patients, the schizophrenics, the panic disorders, etc. The major conditions get admitted and once they're stabilized, they're moved into a less restrictive, more cost-effective environment and step down as quickly as they can. That's why the inpatient days have gone down so substantially. I think it's hard to imagine them going down much more because some of those types of diagnoses need that kind of setting and they need it for a certain amount of time. Maybe there's been some backlash about too much restriction of access in some of those environments because of the horror stories that are out there, but that's really what's behind the drop in inpatient admit rates. Also in the old days, you had inpatient programs designed around the benefit structure, so you had two- or three-week programs to get your child learning or modifying behaviors, and parents put their kids in those programs, so facilities grew just because of those kinds of benefit designs. They may not exist anymore today.

**Ms. Peters**: Can you describe a scenario under which the outpatient visits are also significantly lower in the well-managed environment?

**Mr. Melek:** Is it the state of Ohio you're going back to?

**Ms. Peters**: No, on the original table. Is it just fewer follow-up visits?

**Mr. Melek:** That's what it is. Here's where the arguments start to fly as to what does a well-managed, outpatient clinical program look like? What they're trying to do is manage away the unnecessary visits on the end of an episode through more brief treatment sessions, but there are arguments for and against those kinds of approaches as well. But compared to an unmanaged situation where you might go to a therapist for years, if you get rid of one of those, you can drop your numbers down a lot.

**Mr. Ronald E. Bachman:** First, I want to thank you for keeping the issue of mental health in the forefront by providing facts for appearances and demonstrations for impressions. You and I have both been doing a lot of work in this area lately and it's a fascinating area for me. I would say medication management, to answer the last question, has been helping to keep people out of inpatient, but also shorten some of the never-ending outpatient treatments, so there has been a lot of change in mental health care and the way the providers deliver those services. Focusing on the actuarial parts, a recent study, the "Health and Human Services Report" done by the Substance Abuse and Mental Health Services Administration (SAMHSA), which followed the Hay-Huggins model and Ed Houston's work, showed a very low cost for substance abuse. That study indicated an increase on health care insurance, on average, of about 3.6%, but 3.4% was for mental health and .2% was for substance abuse. None of my models show that low amount for substance abuse. I usually have between 20% and 35% of the total cost going to substance abuse. Have you done any work on that, or can you comment on the outcome of that report?

**Mr. Melek:** I don't have a copy of the report on substance abuse that we had done. Again, as with any report, the starting level of benefits and the degree of health-care management you have are big drivers of what the numbers came to. Ron's referring to the report from SAMHSA and Mathematica. The way I would describe their approach as a two-step project. First, they were doing a compilation of all the studies on parity so the government to come up with some consistency of what we expect the cost level to be for parity benefits. Then they took their own model and their own assumptions to develop their own cost expectations. I was also surprised at how low substance abuse came in -.2% is very low. I think our numbers were pushing 1% or .7–1%, close to what a well-managed substance abuse package might cost over a full spectrum of different health plans.

**Mr. Bachman:** That's consistent with what I've seen, which means that the mental health piece actually could be below 3% in that kind of a package. Could you

comment on how mental health parity has been moving around the country in state legislatures after they get past the cost issue? I think there's a reasonable range of consistency on the cost numbers now, much more so at least than we had just a few years ago. The issue of mandate versus nonmandate comes to the forefront. Do you mandate a mental health parity benefit so everybody shares a lower cost? If you have an option, which many states have today, it can easily cost 10% or more. What have you found in your studies on the mandate versus nonmandate issue and is there an option to follow something along the lines of the Mental Health Parity Act of 1996, which some would argue is not a mandate? Others might argue it is a mandate because it says you don't have to have mental health coverage, but if you do, it has to follow these guidelines. Is there something in-between that you've worked with clients or in other states concerning this? Is there a middle ground between parity and not making any changes?

**Mr. Melek:** I have not. Most of the work I've been involved with has been mandated. Everybody is on board with the same set of benefits by nature, without the selection issues involved with a mandated option or offer and how much potential antiselection you're going to get between users of those services. It could be a very high cost if it was an unmanaged environment, where you're going to attract more acute conditions and the people inclined to want to see their therapists regularly. I just haven't been that much involved in the selection issues with mandated options and the potential cost impacts, but I think they would be substantial. Has anybody else been pricing mandated options for parity benefits in the mental health field in their own programs or states?

**Mr. Bachman:** I want to say one of your own partners, I guess at M&R, did a study for the Center for Policy Analysis on that and came up with 5–10%, which would be consistent with any analysis I've done as well on the option.

**Mr. Robert Comeau:** I want to follow up on the comment you made earlier about compliance with the Mental Health Parity Act regarding outpatient visits where many plans will put a limit on how many outpatient visits per calendar year since they had to take away their annual dollar limit. My question to the group is, have they seen in plans they have been involved with a number limit, like 20-visits-per-year outpatient, and also a per visit maximum benefit, such as $50? In essence, the maximum benefit would be $1,000 in that case because 20 times $50 is $1,000. How many people have seen arrangements similar to that versus saying there's just a 20 visit limit per year with no maximum benefit per visit?

**Mr. Melek:** Who has a health plan with a visit limit and a maximum covered benefit per visit as an integrated outpatient design in any of the plans that they work with? Of the 30 people, four hands.

**Mr. Comeau:** How many the other way?

**Mr. Melek:** And the other way is what?

**Mr. Comeau:** The other way is that there would be no limit on how much the visit would be.

**Mr. Melek:** That would be by far the more common one.

**Mr. Comeau:** Is that the more common one where it would just say 20 visits?

**Mr. Melek:** Sure, 20 visits and no limit as to what they would pay. They would have a copay probably or some sort of coinsurance, but not a limit.

**Mr. Comeau:** Of course, everything would be subject to "usual and customary" provisions. How many people go that way? Can you show hands?

**Mr. Melek:** A lot more hands.

**Mr. Gary F. McHolland:** Steve, I'm looking at Table 2 again, utilization and costs. What happened in 1997 to average length of stay compared to 1996? Is there something wrong with this data?

**Mr. Melek:** I hope not. To some extent a lot of things are going on in this data set. The data we get is contributed from several different plans and insurers. It could have been a shift in what was going on. You can argue the data should have been smoother than this so I wouldn't get too hung up on the year-by-year nature of some of it. The purpose of Table 2 was to show the trend from the earlier 1990s to the later 1990s of the days, the admits, and the lengths of stay, so it probably wasn't nearly as steep in that one particular year as the data would indicate. Medication management being done by a psychiatrist would be in here. I don't have a good explanation for why it would be that steep anyway.

**Mr. McHolland:** I'm still a little hung up on the year-to-year data. On the outpatient visits from looking at the year-to-year numbers, I would conclude that the increased use of psychotropic drugs such as Prozac had no impact on outpatient visits, and that surprises me. Do you have any comments or data that show the psychotropic drug costs over time and how that might relate to these numbers?

**Mr. Melek:** Well, realize that a visit to a primary care doctor for a psychotropic drug is not a mental health visit and a large majority of that is still done in those settings. Medication management being done by a psychiatrist would be there, but

those aren't nearly as frequent as a psychological therapeutic visit would be. What's also happening with this underlying loosely managed data is that, with the shift from inpatient days to reduced levels, there's a natural reduction as loosely managed becomes more managed. Just by the inherent nature of the delivery systems, inpatient days are going down and being replaced with outpatient visits, but outpatient visits are also going down, so you have a stabilizing effect.