RECORD, Volume 30, No. 1*

Spring Meeting, Anaheim, CA
May 19–21, 2004

Session 81D
The Real Costs of Behavioral Health-Care Benefits

Track: Health

Moderator: MARC ALAN LAMBRIGHT

Debaters: PAUL J. FLOYD†
STEPHEN P. MELEK
TED WIRECKI‡

Summary: State mandates have increased coverage for many behavioral health benefits, even to the point of requiring absolute parity with medical benefits. Proponents argue that coverage of mental health benefits defrays other medical and societal costs that develop when mental illness is left untreated or undertreated. Opponents counter that many behavioral health services are medically unnecessary and add layers of cost to an already expensive health-care system. This session summarizes recent trends in behavioral health parity, the impact of mandated benefits on near-term medical costs and methods to effectively manage mental health utilization. Panelists present the "pros" and "cons" of mental health parity. Attendees gain an increased understanding of the issues surrounding behavioral health benefits.

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†Mr. Floyd, not a member of the sponsoring organizations, is senior vice president of business development at Corphealth, Inc. in Fort Worth, Texas.

‡Dr. Wirecki, not a member of the sponsoring organizations, is corporate medical director of Anthem Behavioral Health in Denver, Colo.

MR. MARC LAMBRIGHT: I'd like to introduce our panel. First we have Paul Floyd. Paul is the chief business development officer for Corphealth, Inc., where he heads product development, rating, pricing, underwriting, contracting, sales and marketing. Paul has served for over 20 years in the insurance and health-care-related industries and has had various executive positions in the United States and throughout the Pacific Rim. He has held positions at Prudential, Cigna and John Hancock Managed Care prior to joining Corphealth in 1997.

Our second panelist, Steve Melek, is a principal with Milliman USA. Steve's areas of expertise include health-care product development, management and financial analysis. He has also worked extensively in the behavioral health-care specialty field. Steve is an FSA, a member of the Academy and a master fellow of the Life Office Management Association (LOMA). Steve has spoken at various SOA meetings and Behavioral Healthcare Institute meetings and has published research articles and reports on various behavioral health-care topics.

Our third panelist is Dr. Ted Wirecki. Ted is a senior vice president and corporate medical director at Anthem Behavioral Health. A board-certified psychiatrist, Ted held a full-time private practice prior to his involvement in managed care behavioral health care. We're lucky to have a medical doctor with us today. Currently he's a member of the clinical faculty at the University of Colorado Health Services Center. I'd like to welcome our panelists. I'll be moderating this session. I am the manager at KPMG Actuarial Services.

I want to give you a brief outline of what we plan on doing today. We're going to try and break this into two parts. The course description has required us to do a fair amount, so what we're first going to do is summarize the things that we're supposed to be summarizing. Then we'll get more into a debate-and-discussion type of format. Paul Floyd and Steve Melek will talk about the current state of behavioral health parity with respect to recent developments and impacts.

MR. PAUL FLOYD: In any discussion of the impact of behavioral health costs on the totality of medical dollars, somewhere along the line you have to include what's going on with parity and what's going to happen with parity. We're going to cover it briefly because we hope to be able to show you today that some of the things that people think of as traditional drivers against the health-care dollar have less significant impact than you might think.

We're going to begin by giving an overview of where we are with parity—the best, most up-to-date status that's available. We want to initially talk about parity of coverage by state. There are 35 states with full and limited parity laws on the books right now in what you would think of as a formal, enforced sense. There are nine states with mental health and substance abuse parity: Maryland, Minnesota, Vermont, Virginia, Connecticut, Massachusetts, Rhode Island, Delaware and West Virginia. Only one state, Arkansas, currently has what you think of as full mental health parity, and that's a broad coverage with it.

There are mandated benefit (MB) and mandated offering (MO) laws in 15 states, where either you have to offer it or it's mandated within the benefit. In Georgia, it's a mandated offering. In Texas, Pennsylvania , and Tennessee, it's a mandated benefit. Other states have different levels of mandates depending upon whether there is an offering or whether the state itself, like Nebraska, says you have to offer these if you're offering a medical benefit.

Steve is going to talk about the costs associated with the implementation of parity.

MR. STEPHEN MELEK: It's exciting to see a roomful of people talk about behavioral health-care topics. I've been involved in this for about the past 10 years when I started specializing in it at Milliman. I was looking around Milliman and nobody knew a whole lot about behavioral health care. That was about the time when "Hilary care" was coming along, and that was the big opportunity for the industry to promote parity in mental health care. The American Managed Behavioral Healthcare Association (AMBHA) was formed, and that was the start of a lot of activity, at least the start of a lot of concentrated activity on the federal front with parity. So parity discussions have been around for the last decade. Because of the lack of a federal mandate on parity, states have taken their own initiatives. Various groups have decided that's the right thing to do and have made efforts in that line.

I want to summarize the history for you to provide some information on what has occurred in the past decade on parity as we enter the current year's series of debates on the topic. Not surprisingly, the degree of cost impact on parity is based on three components, although effectively the third one has shown little evidence of having a real cost impact. The existing level of behavioral benefits (mental health and substance abuse) before parity was to kick in is a key driver. The second key driver is a potential key driver, and it is the degree of utilization management that's in the system before parity is implemented and after parity is implemented. It is a real driver to the extent that UM changes under parity. I will talk more about that with some specific examples.

What we have found traditionally is that when managed care comes in to physical health care, it might be able to save 15 percent or 20 percent of health-care dollars based on utilization management, discounted services and those kinds of things. But in behavioral healthcare, historically, there has been a lot more excess utilization and perhaps more ability to achieve greater discounts and services. When managed care is installed in behavioral health care, typically we see, up to double the savings than is seen in physical health care. The third component was related to concern 10 years ago by certain academics and other people who might have had a political interest that there was going to be a huge shift from public sector costs to private sector costs because patients now have unlimited access to benefits in the commercial sector. To my knowledge there has been little, if any, evidence that that has occurred.

Early on, there was no actual cost evidence under parity. It was all theory. Prior to '96, four main studies were done on the costs of behavioral health care. I was involved with one of those. This was all done in the discussions of whether mental health parity should be federally mandated. The actuarial studies were projections based on a summary of fee-for-service, PPO and HMO plans. What would be the impact of parity?

On the low side, Coopers & Lybrand had a 3.2 percent estimate of the impact of parity on health-care costs. On the high side, PricewaterhouseCoopers had an 8.7 percent estimate of the cost increase. We were in there at about 4 percent, and the Congressional Budget Office(CBO) was in there at about 4 percent as well. Over the years, other estimates were made. The progression of these estimates is clearly an indication of decreasing cost expectations. In '97, Mathematica came up with an estimate of 3.1 percent for full parity across a mix of all plans. If there was only parity on an SMI basis, that would result in a 2.6 percent increase in health-care costs. "SMI" stands for serious mental illnesses or biologically-based mental illnesses.

The RAND Corporation came out that year and said, "What if we just eliminate annual limits, similar to what the Mental Health Parity Act of 1996 did? What would happen?" They estimated just $1 per employee per year cost increase for that change. If calendar-year limits were raised to obtain partial parity, it would cost $7 per employee per year. Again, these are all estimates, not actual experience. In 2000, the National Advisory Mental Health Council's (NAMHC) report to Congress said it was going to cost 1.4 percent.

I want to read something from that because it was particularly enlightening to me. In a report to Congress entitled "Parity of Coverage in Mental Health Services in an Era of Managed Care," the NAMHC found that, "based on empirical studies in economic stimulations across diverse populations, managed care approaches and parity structures suggest that the introduction of parity in combination with managed care results in lowered costs and lowered premiums or at most, very modest cost increases within the first year of parity." It also included, "These findings do not support earlier concern about potentially high financial costs caused by parity."

In 2001 the CBO came out with a new estimate that now parity was only going to cost 0.9 percent of total health-care premiums, and PricewaterhouseCoopers updated its estimate of costs down to 1 percent. In a matter of five to seven or eight years, the parity cost estimates from the beginning were in the neighborhood of about 4 percent of health-care costs, but they were down to only a quarter of that level by the start of this decade.

It may well be that in combination with managed care changes, the management savings in medical costs have already been achieved and medical costs are rising again, and now the management savings in behavioral costs are shrinking that

dollar amount so that the overall effect, with a growing base of medical costs, is reducing parity costs over time. I think that is a part of the parity cost reduction, but not a substantial part of it.

Now we've got actual experience in state mandates. In North Carolina, it was determined that when managed care was installed at the same time of parity benefits, the behavioral health-care costs changed to one-half of what they had been prior to parity. This is consistent with what could have been expected with a high degree of unnecessary utilization and low discounts, and then parity kicks in at the same time as managed behavioral health-care. A lot of savings are achieved through UM and discounts. In North Carolina, they identified an increase in the number of patients served from about 6 percent to 7 percent after parity. A large percentage of the reduction in the behavioral costs there was due to inpatient days. Inpatient days were reduced by 70 percent in North Carolina.

Texas saw a 48 percent decrease in costs with managed care for state and local government employee groups. Minnesota saw a decrease in premiums through the Blue Cross plan. Maryland, with full parity, saw a percentage increase that was only 0.6 percent. In Minnesota and in Maryland, where they put in full parity, you might ask what would happen if they blew their cost estimates? Maybe you'd think that in the first year, there would be an uproar afterward and then they'd do something about it. There was no attempt at all to repeal or amend the parity laws after they went in with full parity in those states. That may imply low cost impact. In Rhode Island, there was limited parity. There was just a 0.33 percent increase in plan costs.

New Hampshire was flat. New Hampshire was SMI-parity only. Maine, with SMI-parity, saw the percentage of health-care costs for behavioral health care just tweak up by 0.01 percent after parity was installed. Again, that's the behavioral base over the total medical base, so if the medical base grows enough, that can cover the parity costs when the measurement is behavioral costs compared to total health-care costs.. Vermont saw a modest increase with full parity. They've done an effective job in managing the SMI-parity costs in Colorado. The actual increase has been about 0.2 percent in Colorado.

I want to touch on the talk that's been out there related to parity. These are a couple of the quotes that have been made by significant research and other organizations. RAND, in describing the Ohio state employee program that put full parity in, said, "The implementation of managed care by far overwhelmed the effect of benefit expansion in Ohio." Then RAND, in testimony to the U.S. House Subcommittee on Criminal Justice, Drug Policy and Human Resources, said "The cost of adding full substance abuse parity where no previous benefits exist is only in the order of 0.3 percent." A lot of the parity bills and enactments have set substance abuse aside because there's a lot of recurrence of the problem and life-long battles with substance abuse problems. Parity opponents have tended to win those wars a little more than the mental health parity discussions.

PricewaterhouseCoopers, in a report to the American Psychological Association, said, "To date, there are no examples where mental health parity has been enacted in a state and costs have dramatically increased or a measurable increase in uninsureds has been detected." Our luncheon speaker was talking about the three major problems of cost increases, increases in uninsureds and problems with quality of care. Those still exist, and we will get to that later in the discussion on behavioral health care. Lastly, California was one of the later states to enact parity. Mathematica, in a report to the California Healthcare Foundation, said that the law did not appear to have any adverse consequences on the health insurance market to date.

In the last decade, we've overcome a lot of fears that mental health parity or behavioral health parity was going to cost an arm and a leg, drive huge increases in costs of 4 percent or 5 percent, even up to 8 percent in some of the early concerns, and that was going to cause problems. Setting aside the discussion about whether mandates are good in and of themselves, we've learned in the last decade—Ted's going to talk more about how we accomplished this managed cost achievement—that the cost of mental health parity or behavioral health cost parity is limited. We will also talk later about other benefits of providing full parity benefits.

DR. TED WIRECKI: The biography that was sent doesn't describe in detail what I've been doing for the past 20 years. Most of that time has been spent running a carve-out behavioral health company, PRO Behavioral Health, that a couple of years ago was sold to Anthem Insurance Company. In the past two years, I've been directly involved as a carve-in company, which is a different perspective in terms of running the behavioral health benefits for what now is our approximately 12 million members. Through that 20-year journey, I've seen a lot of changes in behavioral health care, but one of the things that I'm proud of (and it's not easy to be proud of things when you're in managed health care) is the fact that we've been able to keep costs fairly flat.

The cost problem that's been described in the lunch meeting earlier and that we all know about is not a behavioral health-care problem. Behavioral costs have been flat and may have even decreased over the last 20 years. Much of that is because the management has directed care to evidence-based treatments and to choosing modalities and directing care in the direction where positive outcomes occur. We're treating many more patients now in the commercial behavioral health-care system than we were some 10 or 15 years ago. Penetration rates—the number of patients out of a group that are treated annually—have increased to perhaps 7 percent or 8 percent, from perhaps 3 percent, at the same cost.

There isn't much of a debate to be had about parity, given the information that was just presented. The cost is fairly negligible. To give some background on that, costs were managed in the '80s by benefit design. Virtually all insurance benefits had limits on inpatient days and outpatient sessions. There were between 10 to 30 inpatient days, maybe 20 outpatient sessions, with high co-pays. You didn't need a

lot of management then because people would use up their benefits quickly if they had a serious illness. As parity came into effect and as various hospital systems began to perhaps take advantage of some of the insurance benefits, costs did start going up. On a parity basis, the biggest cost has proven to be the co-pay change.

As parity goes, there is the same number of inpatient days and outpatient visits as medical, which is usually unrestricted, but the copays used to be about 50 percent of the bill, $25 to $50, whereas now they're the same as the medical. That effect does translate quickly the following year into some kind of a cost increase. In fact, when I was working with a plan in the east some time ago, we were concerned about that because even a 2 percent increase of the total medical costs becomes a huge increase if you're only responsible for the behavioral dollars. Steve helped us with some actuarial estimates for the increase for parity, and while we were able to get those in place, we did well that year because the increases were nothing like had been expected.

I want to focus on how you optimize costs in a care management program, with little focus on quality, though that's certainly a second major arm of behavioral managed health care. There are several core responsibilities that you have, including making sure that the care meets medically necessity criteria. In behavioral, there's perhaps more room than in some of the rest of medicine for subjective interpretation. Problems of living that might be considered growth issues, personal coaching and those kinds of things often are billed by health-care providers, so there has to be a mechanism to assure that those things are not paid on the insurance benefit because they're not insurance.

The second fundamental bedrock of behavioral health care is that it must be provided in the least restrictive setting, in an outpatient setting if possible or in intensive outpatient if not, but as little as possible in the hospital. Given what we heard at lunch that you have a 1 in 300 chance of dying if you go into the hospital, that's probably a good thing. In my experience not a lot of good happens in the hospital, except for some kind of stabilization. Hospitals can get very ambitious about trying to effect major change. It doesn't work well, and it's cost-ineffective.

On an outpatient basis, it's fairly essential that appropriate medications are used. About 75 percent, if not more, of the behavioral health care on an outpatient basis is provided by social workers, psychologists and other health-care professionals, most of whom do not have the ability to prescribe. People do get trapped in long-term treatments, whereas sometimes within a couple of months of starting appropriate medications, they get better. The care management system must work with the provider to direct patients to get on medication, if needed, to get appropriate cost results. They end their therapy quickly once they get better. Follow-up for the severely ill is essential because these people just bounce back. They keep coming back with more and more hospital days unless there's appropriate care on an outpatient basis.

On a political level, there must be a capacity to make denials. If you are evaluating the ability of a behavioral health-care management system to control costs, it has to make denials and have them stick. There are parts of the country, in the northeast particularly (Massachusetts, Connecticut), where that's extremely difficult because of the insurance regulations and political process, but that has to be evaluated as part of any cost evaluation. Finally, the people who are doing the care management have to have a good culture. Many of the decisions are interpreting criteria—there is a subjective element—and it can happen effectively only when the culture of the group that is doing that is positive and constructive.

The network, to provide adequate coverage, must be multidisciplinary. There simply aren't enough psychiatrists for one to provide all the care, and frankly, they're too expensive. Second, if you can have a system where care is directed, even though there is a cost to that, it lowers the cost of the entire program because you have the ability to direct many of the patients who come in for help to the most efficient providers, and those providers do not have to be managed much. This has been proven to be true. There's probably a 20 percent or 30 percent difference in cost alone, everything else being equal, between a directed access model, where members have to call in for referrals, and an open access model, where members look at a listing of providers and choose whomever they want.

To the extent that it's possible, hospitals need to be directed to focused treatment. If somebody comes in around suicidality, which is the most common reason these days, the treatment must be directed at resolving that issue and what's behind it, not going on other adventures, which happens on a regular basis. You must also have a continuum of care in the network, where you have emergency services and partial services, so that people can be moved down through various levels of care to one that's most appropriate for their clinical condition.

I'm not going to get into any detail on this, but you can't run a behavioral health-care management system on a medical IT platform. You can have that if you have separate modules, but the couple of times I've been involved in these experiments where it was run on a basic HMO-type system, like Facets, it didn't work.

You have to have specific utilization management policies and medical necessity criteria for each of these four core areas: intensive services (hospital-type services), drug services, outpatient services and psychological testing. You can't adequately evaluate, approve or deny care if you're using criteria that are general and directed toward medical conditions.

The biggest savings, as has been mentioned, are on the intensive side. Sometimes, in a loosely managed system, you can have as many as 30 inpatient days per 1,000 per year. With reasonable management, you can bring that to perhaps 25 percent to 50 percent of that, but invariably, as soon as management lessens, that number starts creeping up. It happens in every part of the country and in every area. There's a tendency for patients, doctors and hospitals to relax, take it easy in the

hospital and take a fairly long time to get out and provide treatment that can be done much more efficiently. You have to stay on top of that, make authorizations in fairly small segments of one to four days and have an average length of stay of about four to eight days. Good discharge planning is essential to avoid a revolving door situation.

Substance abuse treatment is broken down into two areas. One area is intoxication and withdrawal, meaning people who come in because they're severely drunk or withdrawing from drugs. The other area is prevention of relapse. The vast majority of care for relapse prevention, which is most of the care, can be done in an intensive outpatient setting. There are specific criteria for that. The 30-day programs that have been historical in this country go back to military traditions where soldiers were given 28 days for their substance abuse treatment, a day to get there and a day to get home. There's absolutely no basis in any kind of science to substantiate that. With rare exceptions you get the same outcomes in intensive outpatient programs. Those are very cost-effective treatments.

Outpatient sessions are an area of considerable debate. Some insurance companies now have moved away from doing general authorizations for outpatient sessions. The verdict on that is not yet out. I'm a little skeptical. Cigna recently moved in that direction. However, you do want to encourage medication management, and that does not have to be authorized. But general sessions, after about eight or 10 sessions, need to go through an authorization review process to contain costs. I already mentioned the issue of referral to psychiatrists when medications are needed. If that doesn't happen, treatments just go on and on.

The main thing about psychological testing is that it used to be routine testing. People would come in and get tested as part of coming in to see a practitioner. That's more or less the same as going to an orthopedist and getting an MRI immediately as a part of the routine. It doesn't make any sense. A lot of educational testing has been done in this kind of context. That has to be evaluated, approved or denied.

There are some things that have a positive ROI. There are a lot of things that can be done, but some things have an ROI, like a case management system. For patients who leave the hospital, if you can actively outreach them, make sure they see their providers, take their medications and do standard case management, the cost of that program is offset by fewer hospitalizations. Medication compliance programs can be extremely effective and are often subsidized by the drug companies in terms of avoiding relapse.

Bipolar and schizophrenia disease management programs—that's a hot topic these days—do have a positive ROI and certainly add a value to the program. Depression disease management is a much more controversial subject from a direct perspective. There's no question that depression disease management is cost-effective from the viewpoint of reducing absenteeism and possibly a positive effect

on medical costs. It probably does not have a positive effect on behavioral costs and may increase behavioral costs. There's a big push lately on integration with primary care, as there has been for the past 20 years. There is a value to that for a small subset of patients. Most patients do perfectly well in a separate system one way or another, but for patients who have comorbid conditions, both medical and psychiatric, integration can lead to more effective treatments, better outcomes and lower costs. I think Paul will address that later in his presentation.

MR. LAMBRIGHT: Paul will discuss the impact of behavioral health costs on the entire health-care dollar.

MR. FLOYD: We've seen the impact of parity, which is minimal, as is the implementation of parity. There are those of you out there who have heard inside, what are you going to do if they pass full federal parity? How are we going to handle that? What is the contingency plan that we have in place? What's happening with our state laws? It all depends on how you approach it as an organization, your approach as actuaries and how you're rating it. The next part about it is that we've seen that clear, high-quality clinical programs used to manage medical benefits and behavioral benefits together can achieve some success. That's what we're going to get into in some greater detail.

We already know data. We're already aware of it. From '98 to 2002, there was a 50 percent increase in health-care costs on a yearly basis as we go across the past five years. With regard to behavioral health care, runaway behavioral health-care costs of about 20 years ago fostered the development of what was approached as a carve-out. Why did carve-outs come about? Health-care organizations, health insurers and people who cover medical benefits and their costs associated with it had no expertise whatsoever in behavioral health. It was a foreign animal. What was their approach?

The approach originally came out of Kaiser Permanente. The approach to it was, how could you be able to have the degree of expertise necessary to truly manage appropriate care in behavioral health care and manage the associated expenses with it? In '80, you could take a look at your benefit dollar and say that it was typically around 8 percent to 9 percent, in some cases as high as 12 percent, but a good average would be 8 percent to 9 percent. With the advent of carve-out programs and other behavioral health management programs, that shrank. Most organizations right now are seeing 2 percent to 4 percent. Overall, an average would be more like 2 percent to 3 percent of the health-care dollar being spent on behavioral health care.

As far as treatment of mental illness, there's treatment in the mental health sector, treatment in the general medical and then treatment in other environments. You're looking at about 10 percent being treated in a mental health sector. You're looking at a total of about 19 percent being treated in general medical and other associated visits, and about 71 percent of mental illness conditions not being treated at all.

Let's take a look at annual claims expenditures for 250,000 adults with and without behavioral health-care services. Let's take a look at the changes associated with medical service use only, and then comorbidity in medical and behavioral health service use. Going from '00 to '01, both with medical service only, looking at the expansion and then looking at the increases when you have comorbid conditions, there is an increase on a year-to-year basis between medical benefits alone. But if you begin to take a look at the increases and the associated increases when there's a comorbidity of behavioral health, you can see that pharmacy increases are substantially above that and then the introduction and increase in behavioral costs go even above that.

For example, consider a study looking at health-care spending across a population of 206,000 people in '01 for patients with chemical dependency and mental health service use as compared with expenditures when you have a medical condition associated with it. Behavioral health issues are a significant driver to increasing medical costs. Again, what I want to bring you back to is this thinking in the process that so often we're focused merely on the 2 percent to 3 percent of direct costs for behavioral health treatment, not even including the pharmacological costs.

A recent study—this particular one was taken from someone whom we've been working with who is not only a psychiatrist but also a biostatistician—concluded that when behavioral health issues exist with medical conditions, overall health-care costs rise significantly. Within general medical use only in this population they saw '01 over '00 had a 14 percent increase in medical services and a 24 percent increase in pharmacy. I don't know what your experience has been across some of your population. Perhaps a lot of that has been abatement of trend that's primarily been associated with different approaches to your benefit programs or uses that you've had on Rx management companies.

Within this population, it also showed that when a behavioral health issue existed with a general medical condition, the dollar increase was substantial. They had not only the same 14 percent increase in medical services and 24 percent increase in pharmacy, of course, but in addition to that, there was a 4 percent increase in what are called "extra" costs in general medical and a 27 percent additional increase in "extra" pharmacy associated with it, plus an additional 19 percent in behavioral.

What does that mean? The overall increase in this population of actual dollars spent rose because of the comorbidity of the two conditions. It was a 5.4 percent average of the annual costs versus 1.5 percent average in general medical services. We've been taking a look at studies over the past couple of years now. In taking a look at even the most current studies that are available—26 studies as separate indicators—we found that psychcomorbid conditions lead to increased hospital length of stay, an increase in postdischarge costs, an increase in emergency room costs and a substantial increase in readmissions.

Make no mistake about it that a lot of people out there currently who are offering

medical benefits may say they have internal management of the behavioral health benefits. In reality they have something that operates a lot like a carve-out program internally. We're going to get to what that really means. Continued focus on the 2 percent to 3 percent only of the direct cost prevents an expanded view of the impact of behavioral health on more than half of the total health-care dollar. If you focus on the 2 percent to 3 percent of costs, what you're forgetting is that 60 percent of the health-care dollar has a substantial impact made on it by behavioral health: direct costs, disease state comorbidity costs, psychopharm costs and high risk population costs. Comorbid conditions substantially increase the ongoing operating costs associated with it.

Let me give you a few ideas about that. Within certain physician and office visits, lab costs and other costs, there's about 9.5 percent impacted dollars on behavioral; in high-risk populations there's as much as 25 percent. With working antianxiety, antipsychotic and other prescription drugs, there's a minimum of 2 percent. Antidepressive prescription drugs have an impact of 1.6 percent and greater. Direct traditional behavioral health-care costs are, again, in that 2 percent to 3 percent range, about 2.5 percent. But 26 percent of the dollars currently associated with chronic conditions can be impacted in costs when you're treating behavioral and medical together in that environment.

Let me give you the idea of comorbidity and psychological illness within chronic physical disease states. I'm going to take a few of the larger ones that can be associated. Pick arthritis. In studies and cases that have been looked at, as much as 25 percent of individuals with arthritis have an exacerbating condition because of behavioral health issues. For cancer, it was 32 percent. For diabetes, it was as much as 23 percent and higher. For heart disease, it was 34 percent. For hypertension, it was 23 percent. The list can go on. In medical illness, approximately 50 percent have associated behavioral symptoms. What are some of the issues and physical conditions that you can take a look at? Diabetes, alcohol withdrawals, spells, pain, long hospital stay, Parkinson's Disease, and speech or motor impairment. But psychological illness shows 80 percent with physical symptoms: depression, alcoholism, somatization and substance dependence, psychosis and autism.

If you put up large numbers in front of any actuarial group, the first thing the actuaries are going to say is, "Okay, let's debate that for the next hour." We grabbed the two lowest examples that we had in dollar return and decided we'd talk about one of them as an example in delivering. We'll talk about economic savings with delirium interventions. The prevalence of delirium during hospitalization typically ranges anywhere from 10 percent to 30 percent. The average length of stay, however, is two times that of the nondelirious patient.

If you run conservative numbers of 0.1 (prevalence rate) times $3,000 (differential hospital cost) times 10,000 admissions, divided by 3 (prophylaxis rate), the savings is $1,000,000 per 10,000 admissions. Look at the savings impact you can have on

the delirium patient who has that comorbid condition, plus maybe other comorbid conditions and psych disorders along with a physical disorder. The outcome of that is you can impact a percentage savings on it that is typical to what the total traditional view of expenditure on dollars in behavioral would be. Again, that's just one of multiple examples.

How can you achieve that? Integration is the new solution to a new problem. As Ted has discussed, in the past couple of years a number of organizations have moved to bring behavioral health management back inside. It's the whole approach to cost of behavioral and medical integration plus additional programs that can be associated with doing that. Carve-out traditionally has been viewed as kind of a black box. That was fostered by what happened in the behavioral health carve-out area. They're controlling medical costs; they've already been able to reduce them from 8 percent to 10 percent in a number of cases, sometimes higher, back down to that 2 percent to 3 percent. It's that black box.

The approach typically has been, "You guys manage behavioral benefits. You're going to do a good job of it. We've taken a look, and you've got all the qualifications necessary to do it. You've got a good track record, and you're willing to put your money where your mouth is with risk and so on , so we're going to give you a certain amount of money. We're going to capitate that to you and basically we don't want to hear anything more from you. We're going to give you a certain amount of dollars, you make the problem go away and we don't care anything else about it." However, what we're saying is this. If you want to achieve the benefits that can be seen from addressing behavioral as a comorbid condition with medical and be able to address that 60 percent of the health-care dollar that can be impacted by including behavioral health-targeted treatment and those programs with it, whether it be things such as high-risk health coaching or taking a look at controls and use on pharmacological, that traditional approach no longer works.

It cannot work as fruitfully as literally taking responsibility for behavioral health management back inside. I would like to make a point that about 60 percent of all the business that my company has is in behavioral carve-outs, so I'm standing here saying that for companies that cannot and will not progress forward, you're going to have to continue with the behavioral health carve-out. Understand that companies like ours will be more than happy to handle it for you. But when you get serious about attacking the impact of health-care dollars on behavioral, insourcing it is the answer.

The next part in this is the data warehouse. You've got to get to the point where you've included detailed, ongoing, true behavioral health-care claims along with your Rx and along with your medical. As long as it's carved out, you're always going to be limited in what your response is and the amount of data that they provide back in doing that. Next is solid data analytics. It does more than take a look at a good Rx predictive modeling. You've got to be able to include a complete analysis of what's happening across the board because until you combine the

behavioral along with the medical, you can't begin to see how to impact those medical dollars along with the comorbid conditions of behavioral.

Next, we believe that the data have shown that rather than to take programs that address this issue, including various disease state management, it's better to take a look at solutions testing rather than to try to roll that on the basis. Back in the beginning with Cigna, especially, but also back in the beginnings of John Hancock's managed care division, one of the things that would happen is you would go to a location in Chicago and they would say, "I know you're going to be able to see lots of different sites around the country, you're going to go here and there, you're going to talk to people, but you have to understand that Chicago is completely different." Then you'd go to St. Louis. St. Louis would say, "I know you're trying to have cohesive programs. I know you're trying to get your approach to case management and controlling of costs and rating and pricing and everything else under control, but I want you to understand that St. Louis is totally and completely different from Chicago."

On and on the story goes. We're saying that research so far seems to indicate strongly that a good way to do that is to identify a subset of population with which you can apply the results of data analytics. Boil that down. First you're going to ask, "What are the things we're doing right as an organization?" This is followed by, "What are the things we're doing that we're throwing money at that don't have any solid results? What are the things that look like we should be doing something about?" For those various elements of it, set aside what amounts to a petri dish in a subset of population. Set those aside, institute programs with them and see which have the best value and financial proposition to them before you roll them out to the rest of the population, which is a solution applied. Steve is going to take a look at some of the financial numbers, in addition to those that I covered.

MR. MELEK: I want to stir the pot a little bit. I might have left you with the impression that there are no problems in behavioral health care any more. We've got this parity thing under control, and organizations have behavioral health-care costs managed well, with trends limited to small increases. While all that has been true, I think what Dr. Simmons, the keynote speaker, had to say about cost and poor quality issues definitely applies to behavioral health care. It might apply in places that you haven't been exposed to so far, and I think it's the coming front. There are some things I want to talk about briefly before we open this up for discussion. We're interested in what you have to say, what you have seen and what your thoughts are about parity and the future of behavioral health care.

I want to talk a little bit about the amount of behavioral health care that's delivered in primary care settings, symptomatic treatment of behavioral health care, trends in spending in other places besides specialty behavioral health-care organizations and last prescription drugs and formularies. All of these items are contributing to some rapidly increasing behavioral health-care costs outside of the specialty behavioral health-care delivery system.

What does the situation look like? Fifty percent of mental health-care cost is delivered by primary care physicians (PCPs). Only a small percentage of the population with mental and emotional disorders will ever go see someone like Ted, our guest psychiatrist, in a mental health professional specialty. If most of these people are getting treated in the primary care setting, how many minutes do you visit with the primary care doctor when you're there? Maybe 12 to 16 minutes. How much time is spent with a physician extender during that time, and how much time do you spend with the doctor? This is important for issues that I'll get to in a minute.

One of every four patients in a primary care setting has been proven to have a diagnosable mental disorder. Fifty percent to 70 percent of primary care visits are primarily for psychosocial or symptomatic treatment. When a PCP does spot a patient who needs specialty behavioral treatment, 50 percent to up to 90 percent of those patients will not comply with a referral for a variety of reasons and will never go see the behavioral health-care specialist. Two-thirds or more of all psychopharmacological drugs are prescribed by PCPs, not by psychiatrists. In recent years it has been shown that about 7 percent of patients who visit their PCPs walk out with a psych drug prescription. In a primary care setting, 90 percent of the 10 most common complaints don't have an organic basis.

I picked up a recent headline here from the Associated Press. It says, "Behavioral Drugs Top Kids' Prescriptions." I want to read a few things for you from this article. "As more children pop pills for attention deficit and other behavioral disorders, new figures show spending on those drugs has for the first time edged out the cost of antibiotics and asthma medication for kids. A 49 percent rise in the use of attention deficit hyperactivity disorder drugs by children under five in the past three years contributed to a 23 percent increase in usage for all children, according to an analysis done by Medco Health Solutions. The chief medical officer of Medco said, 'It certainly reflects concerns of parents that their children do as well as they can.'"

We heard from our speaker yesterday morning about the health-care system representing the values of Americans and our desire to get the best value in health care for our patients, for our family and for our kids, but you see some of the results of this. "Use of behavioral medications has been controversial, especially for kids. Some experts say it's not necessarily a bad thing that these meds are being used more, but that the rising adolescent use of antidepressants is a concern because there's little proof that they work in young people and some evidence that they might increase suicidal tendencies." I'm going to come back to that later in my comments.

I have gross numbers from the National Health Accounts, the macroaccounts from the Substance Abuse and Mental Health Services Administration (SAMHSA). I have the 10-year tracking from '91 to '01 of how private insurance expenditures for behavioral health care have gone. Inpatient hospital spending dropped dramatically

during the '90s and then started inching up again after '00. Outpatient hospital and more cost-effective alternatives like Ted talked about have increased and residential costs have also increased.

What I want to point out is that the percentage of all health care spending on behavioral health care in all of these activities has gone up and down within statistical fluctuation, but it's been generally flat for a long period according to this data at 3.5 percent of all health care. This spending includes psych drugs, which in '91 were $1.3 billion and in '01 were $8 billion in costs. Back in '92, professional behavioral costs made up more than 50 percent of all behavioral health-care costs; recently that's down to about one-third of all behavioral health-care spending.

Facility costs, including inpatient and outpatient, made up about 40 percent early on; that's down to about 20 percent through effective management by organizations like Paul's and Ted's and other managed behavioral health-care organizations. But who's minding the pharmacy? Who's minding the primary care doctor's use of all antidepressants? If they're prescribing 67 percent or 75 percent of them, there's an increase in costs that is not managed by any managed behavioral health-care organization. I think there has been one attempt to try to do something like that, and it was a disaster among the Tennessee Medicaid community.

I have a few other facts from SAMHSA data. The trends in outpatient use and inpatient use over the course of the past decade show how well-managed even the unit costs within behavioral health care have been. Ted talked about the use of a broad spectrum of professionals. In what other physician specialty do you see the unit costs for professional services go down over a period of about 10 years? That's because of the substitution of alternatives to psychiatrists and psychologists in some markets. The average length of inpatient stays has gone down dramatically. Inpatient admits have dropped by 50 percent. However, prescription drug utilization has gone up. The number of scripts taken per patient is going up. The average cost per script is going up.

Our Milliman health cost guidelines compare a loosely managed delivery system and a well-managed delivery system. It includes all payers and typical benefits. I want to compare the psych drugs with the rest of behavioral health-care specialty costs, not including any PCP visits, etc., that may relate to behavioral disorders. Including member copays, the $5 to $6 average per member per month cost in a loosely managed health plan is maybe down to about $3 or $4 per member per month with successful management. However, the psych drug costs have risen to the point that they now exceed all of the money you're paying for specialty behavioral carve-outs.

I want to address the formulary commonly used for prescription drug benefits. I think actuaries should have a stronger role in what's going on with formularies in managed care plans. For example, how many antidepressants do you need as

preferred drugs in your formularies? Are they all equally cost-effective? You walk into a psychiatrist's office, and if you're suffering from depression, he might say that you need to go on an antidepressant, and that's a good thing. Which brand do you want to go on? Wellbutrin has these side effects. Prozac has these side effects. There are Paxil and Zoloft. You have all of them, all from different drug companies. How many do you need on a formulary? There's only been one generic until recently, and it's Fluoxetine for Prozac. It costs maybe one-eighth of what all those other brand drugs cost.

How does your drug utilization management program work? I want to refer to a study we did for a large state employer group of the number of patients that were prescribed antidepressants. What disturbed me about the findings from this study, from a cost standpoint and from a quality standpoint, is why was Fluoxetine used so sparingly by all the practitioners out there? We were effectively doing this study to try to evaluate quality in behavioral health care outside the specialty behavioral delivery system and also to analyze the medical costs of patients after they stop taking their antidepressants. Hopefully, antidepressant treatment ends because patients are cured, and they're healthier.

If you don't know a lot about antidepressants, they're not like your average antibiotic or Advil. They take a while before they effectively work. The experts in psychiatry believe that a minimum of six months of ongoing antidepressant treatment is necessary for major depression after symptom remission, maybe up to 12 months of continuous treatment. That's a long treatment period, but that's not the entire problem. The other part of the problem is that the antidepressant's side effects don't wait nearly that long. They come in in a matter of days, and there are lot of problematic side effects. Remember that primary care doctors prescribe two-thirds or more of the drugs with maybe five minutes of interaction with a patient, and there's often no education of the patient as to what to expect. The PCPs write them the script, and out the door they go with their prescription for Wellbutrin or Prozac or whatever they asked for. That's the way the system is.

The primary care setting is, in some ways, an assembly line. The doctors have patients waiting in the office. They've got to get to the next patient. They've got to move them along. They're treating symptoms. They often function in a world of fee-for-service reimbursement where the more patients they see, the more they earn. Lately, we're going further and further away from managed care and capitation of providers. When we go back to a fee-for-service delivery system, we've got that financial disincentive back in operation. If 75 percent or 80 percent of patients who walk in the door of a primary care practice have a symptomatic disorder and it's not biologically based — it's headaches, it's tension, it's diarrhea, it's backaches or whatever — the symptoms could have their origin from depression or stress, but the primary care doctors are not recognizing it. They're treating the symptom, and the patient comes back in another week or another two weeks for treatment of other symptoms.

In this large group of state employees, we saw double the national level of antidepressant use among the members. Knowing that the patients need to be on the antidepressant drugs for six months if they're going to be healthier, it was disturbing to me to find that one of every three patients in this group never refilled their antidepressant prescription. If you want to consider waste in health-care cost as an item of debate, I would say that one out of every three antidepressants that never get refilled is a large category of wasted health-care expenditures. Why and how are the primary care doctors prescribing them? Why are the patients not adhering to the protocols of treatment? There are several contributing factors, but this is an opportunity to change the delivery system in some effective way.

The other disturbing statistic from this study was that if six months of treatment is necessary for most depressive disorders to get full recovery, we found that one-third of the patients never refilled once, and two-thirds of the patients never made it to six months of continuous treatment. In my mind, this is another bucket of potential wasted health-care expenditures.

We also did an analysis of other medical expenditures for all these patients that were being prescribed antidepressants by their primary care doctors. We had access to all the health-care costs, including prescription drugs, medical costs and behavioral costs. We found a large amount, of other medical expenditures for these members, inpatient and outpatient, with behavioral diagnoses among their primary and secondary disorders. Clearly, these patients were not always getting healthier through proper antidepressant treatment through their primary care doctors. Their symptoms caused other effects.

We didn't do a comprehensive analysis of all this, because that wasn't our charge, but I'm throwing it out there for all the actuaries. How much can we change the cost of the delivery system? How much disruptive innovation can we be a part of? Is there a better way for how behavioral health care is treated outside of the specialty setting and in a primary care setting? There are many reasons why people like you and I, if we have a behavioral condition, might not want to go see someone like Ted. "He's a psychiatrist. I don't want to go see a psychiatrist. What will my neighbors think? What will my employer think? I can go to my primary care doctor. I know him. I'll ask him for a script." But that's not working. Look at the cost differences between the prior treatment period and the posttreatment period. If it was effective, the postperiod costs would be lower than the prior period costs, at least by the average amount of the medication management visit to the PCP every quarter. That's going to be about $25 or $35 on a PMPM basis. Some of these drugs, like Prozac, were effective in this population. On the other hand, you see some ineffective drugs, too.

I wonder whether in the pharmacy and therapeutics (P&T) committees of all of our organizations, when a new drug or a new level is promoted and when are we asking if we should add it to our preferred formulary, are doing a thorough economic analysis of the cost/benefit impact of these new drugs, or is this just another

version of a treatment that is not nearly as cost-effective cost as a treatment that we already have? Do we have to keep piling on more and more options for patients to choose from and for the pharmacompanies to market and advertise to? You can't turn on the TV for more than 10 minutes before you see another direct-to-consumer advertising for some drug. They all keep on getting added, for the most part, to our formularies.

Take these same drugs and look at the senior population, the retirees, for this group. It's quite interesting. On the under 65 chart, Prozac and Effexor were at the top as being most cost-effective. Wellbutrin and Zoloft were at the bottom. Here, for the retirees, Wellbutrin is up at the top, and Fluoxetine and Prozac are closer to the bottom. My point is don't assume that the same drugs for the same population have the same treatment efficacy and the same cost-effectiveness. There is a bit of randomization in some of these drugs. Ted might get into the debate on some of that. The doctors really don't know which one will work best for any given patient. In the case of depression, you've got all these alternatives, and it's very much an individual treatment effectiveness.

You might start out with one drug and see if it works, and then go back and see your doctor in another four to six weeks. If it's not working for you, work with them to get a different drug. Shift gears and go on to another one. You don't want to stop; you don't want to throw it in the garbage can like one-third of the population was doing. I propose this as one of the debate issues for the last 20 minutes of our discussion. What are the problems and challenges in behavioral health care as we go forward? What's the future of the traditional carve-out company? Is the parity discussion dead? Should we have full federal parity?

MR. LAMBRIGHT: We've heard quite a bit. There's certainly some disagreement on the appropriate level of access. Should everybody get everything? Should nobody get anything? We're going to start with Ted and get his input on what type of access people should have to behavioral health care.

DR. WIRECKI: I don't think that's much of an issue anymore. The access question is one of open access. That's not what's driving cost, as has been demonstrated, closing access or not. I would like to hear from the audience. I want to make one comment. If I worked for one of the other drug companies mentioned in this presentation, I would walk out of here feeling that we've done a wonderful thing. I think there is some truth to that, that the decrease in costs from the 8 percent or 9 percent 20 years ago to now, on the professional side, has been because of the development of new pharmaceuticals that have fewer side effects and work well for a lot of people.

Having said that, the other side of that is, in terms of Steve's comment about what antidepressant is used in primary care, my experience is that the real answer depends on who was the last drug representative in the office, what samples were left, and what conference you were just at, rather than any kind of evidence-based

determination, partly because there isn't any evidence, and most antidepressants for nonresistant patients, which are the vast majority, work equally well. There are a lot of drugs going generic. Prozac was the top seller that went generic, and it's not so popular any more. Does it not work as well? No, it works just as well, but nobody is providing samples and nobody is promoting it as Eli Lilly shifts its attention to other drugs. As far as formulary control, we want to have access to medication, but access to expensive medications can and should be contained.

MR. MELEK: Well said. I think that's true. As I was saying before, there are new opportunities for actuaries to get involved in areas that we haven't been in before. It's disturbing the way the clinical delivery system is working, as to how the primary care doctors are prescribing 70 percent or more of these medications. Why not have a protocol that at least, if they're all equally effective, you start with one of the generics, and if that generic isn't working, move on to one of the brand alternatives. The drug companies are having too much effect with all their marketing in the psych delivery system. It's a shame that we can't get a better system of operations in clinical delivery. Maybe we have to create new financing incentives for the primary care doctors to do the right thing. Maybe we just have to get their attention in creative financial ways to get them to change their habits. Clearly, there's a huge opportunity to limit a category of waste in the system today.

MR. JOE BOJMAN: I was curious about the drug study. Were those patients who had been on those drugs for the six to twelve months?

MR. MELEK: No. Those were all the patients who were prescribed antidepressants. Some of them could have been on just for one month; some of them could have been on for six or more months. The study was following all the patients during their treatment compared to after their treatment to rank the cost-effectiveness of the different types of antidepressants. We didn't normalize for duration of treatment, which is going to account for some of the variation. I just thought it was a good example of what we're not doing as far as economic analyses of all the different drugs that we keep adding to covered benefits, and whether it is the right thing to be doing from an actuarial perspective or product perspective.

MR. BOJMAN: Certainly. I was just wondering whether there are certain drugs that have greater side effects, and thus the duration of time that people are on them is less, and as a result they're less effective? That's more of a clinical pharmacy question.

DR. WIRECKI: If you're talking about antidepressants, there are certainly variations in side effects. Some make you sleepier. Some make you more agitated or more awake. The drugs are matched by the side effect profile in relation to what the symptoms are. It's subtle, and for a lot of people it makes no difference whatsoever.

MR. FLOYD: There's another major thing that should be brought out in

consideration of the waste. It's not just selection of product that you get involved with. The point can't be made enough that if individuals are not being appropriately monitored with use of their prescription drug, that cycle just continues. During the mid-'90s, various surveys were done which showed that if an individual went to his or her doctor evidencing a certain number of conditions and walked out without having a prescription, that person felt ill-used by the health-care system. Doctors are reacting also to the needs of the patients, just from an overall medical delivery portion.

What happens is the patients will get diagnosed typically within a PCP, within which you can get a general medical type of community. It isn't just that they get prescribed an antidepressant, for example, but often they're underdosed, so an individual does not see any real reaction or any improvement. The patient goes off of it or perhaps the patient starts feeling better, and there's no true reversal, so the recidivism within that population can be seen over and over again. Individuals will go in, even if they get something at the particular appropriate strength. They don't have their checks, and it'll go for a period of time, and then they'll go back and get another, and then they'll go back and get another, and go back and get another. They're not getting improvement at all; they're just completing that cycle over and over of partial addressing their condition.

MR. PAT HENNESSY: I have a question for the doctor. I'm concerned about the youth today. It seems like we're handing out AD&D pills and behavioral pills like M&Ms to these kids. When these kids grow up, and they've been taking these for years, are we going to see a real spike in utilization of these drugs? Are they going to be on these for a long duration? Are these going to develop into a long-standing problem in which the utilization is going to skyrocket as all these kids start coming through and start taking these as a normal way to control their behavior? Are there other things they should be doing? Why is there an epidemic now of overprescribing these behavioral drugs when in the past we've never seen anything like it? What is going to be the future impact for those kids that are on these drugs now, and how will it impact behavioral health going forward?

DR. WIRECKI: That's a very good question without a clear answer. The biggest single driver is a combination of the development of new antipsychotic drugs (particularly with adolescents) and ADD drugs that weren't available and then the incredibly effective job that the drug companies have done to promote the utilization of that, both in public advertising and working directly with the doctors. I think that's what drives it. There is a lot of prescribing for what might be described as conduct-type disorders, which should be handled through other ways with a true psychiatric diagnosis, which isn't to say there aren't a lot of kids with ADD that are benefiting a lot from some of these drugs.

We have no idea what the impact of these drugs is on a developing brain. We barely know what they do on a mature brain, so to predict on a population basis how that's going to physiologically affect these kids as they grow up is unknown.

However, they will certainly get used to the idea of taking pharmaceuticals to control and affect their behavior. I would think it's reasonable to assume that in a general sense their drug utilization, both prescribed and possibly not prescribed, will be dramatically higher than it is now.

MR. LAMBRIGHT: What are the appropriate prescription benefits for the psychotropics? When you're designing a benefit, what should that benefit be?

DR. WIRECKI: There are many generic drugs that are effective. For most behavioral conditions, such as schizophrenia, depression and ADD, there are now generic medications, the cost of which is reasonable. You can probably make a good case that with some rare exceptions, generic drugs should be the first line of drugs, and the nongenerics should be reserved for treatment failures or more complicated cases. For example, I read recently that now in England there's only one statin, Zocor, that is generic, that's available through the public health service. It's a drug with a huge financial impact.

I want to take a minute to address compliance issues. Compliance and adherence of patients taking medications are awful, maybe at 40 percent or 50 percent for most drugs. You can affect that with some real benefits to health-care status and costs. We've been doing a little study for about a year with severely ill bipolar patients. They get their medications through our internal pharmacy benefit manager. We've got a system where if they don't refill their medication within five days, we get notified. It's more involved than that, but the short version is that our psych nurse gives them a call, asks them why they haven't filled their medication and supports them with that. We've been able to increase the compliance from something like 48 percent to about 75 percent, reduce hospitalization by a factor of about 40 percent for this condition and affect overall health-care costs by a meaningful number. That study is not published yet, but it will be. It suggests that part of it is making sure as a system that people take their medications, particularly in the most difficult conditions.

MR. FLOYD: There are cost savings that can be associated with being able to do things like a nurse help-line or high-risk health coaching. The costs of those programs are more than sufficiently offset by decreasing of other health-care costs. There are various people who have been writing about this for a long time. It's just that before, you didn't have the numbers to put around it. I remember reading a report that Steve did on medical cost offset about 10 years ago. In doing medical cost offset, we're just now being able to get our hands around the true numbers behind the financial impact they're having and the savings you can expect with these comorbid conditions. You begin to see the biggest progress, appropriately so, when something moves into the stage where you have all the data that you can take a look at and can do proper data analytics to get real numbers.

MR. MELEK: The lunch speaker mentioned the impact of health-care costs on other things, such as retirement benefits. If you look at total costs to employers and

payers, the American Medical Association came out with a report recently that depression was costing employers $44 billion a year in presenteeism and absenteeism. That dwarfs the cost of health care from behavioral health-care benefits. We need to get employers' attention that the system currently is not nearly as effective as it could be, and we can try to save a lot of money in health-care costs, productivity costs, absenteeism costs and so on by more effectively treating behavioral health-care disorders and maybe save pension plans at some point down the road.

MS. MARY CHANDLER: I noticed that some of the states that mandate mental health care make a distinction between serious mental illness and other mental illness. One of the states does not require you to cover serious mental illness, or maybe it's that the state requires you to cover it under the medical part, like the state of California. Do you know what the rationale behind that would be?

MR. MELEK: I thought the California parity bill required parity for serious mental illnesses. Maybe I misinterpreted that.

MS. CHANDLER: It may be that when they list out the benefits on the policy that the nonserious mental illness has a lower level of coverage.

MR. MELEK: Right. There is a separated mental health benefit for the nonbiologically based benefits, but the biologically based benefits are not considered as falling under the mental health benefit. They're considered medical, the same as any other medical-type condition.

MS. CHANDLER: That would make sense. Thanks.

MR. MELEK: If anyone in the audience is antiparity at this point, feel free to step up. I know the American Manufacturers Association has been a large opponent to it. I know there are people who say you shouldn't mandate benefits at all. Let the health plans decide what they want to offer. Let the buyers decide what they want to buy and don't start requiring mandates for A through Z. But I think we have increasing proof that this is a sensible thing to mandate because you can save money more. This is the soft balloon theory: if you squeeze the soft balloon and don't provide benefits on one end, it shows up in other places like primary care settings and comorbid disorders.