

Preparing for parity: Investing in mental health



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The world we have made as a result of the level of thinking we have done thus far creates problems we cannot solve at the same level of thinking at which we created them.

- Albert Einstein

The Troubled Asset Relief Program (TARP) put in place last fall was not only an unprecedented bailout of the banking system; it also contained an amendment that will cause major changes in health insurance. Starting this October, most health plan renewals must offer coverage for behavioral disorders on par with physical coverage. Historically, many insurance plans and employers have limited coverage for behavioral disorders, often by using benefit designs that differed greatly from physical coverage. The outlook for how these new rules will affect the industry covers a wide spectrum, but one thing is certain: group health plans and employers must begin preparing for parity now.

Some health plans and employers worry that mental health parity will erase profit margins, but others have taken a more positive view. Over the last two decades, the managed behavioral healthcare industry has shown how proactive and effective treatment can be a form of preventive care when weighed against costlier physical and behavioral problems arising from untreated behavioral disorders. Forward-thinking plans and employers may use this parity requirement as an opportunity to improve their approach to behavioral healthcare. Ample opportunities for such improvements certainly exist.

This parity mandate does come at a time that is especially difficult, but crucial. Mounting job and pension losses, healthcare benefit reductions, and increases in COBRA coverage will be accompanied by increases in anxiety and depressive disorders. The growing need for behavioral healthcare services is unprecedented, and the potential change from historical cost levels may be significant. That's why careful planning for these parity requirements is essential, and must include the impact on physical as well as behavioral healthcare costs.

HOW WILL YOU BE AFFECTED?

The new rules require coverage of mental health and substance abuse disorders on par with medical and surgical benefits, and apply to any group health or self-insured plan covering more than 50 employees. This means that deductibles, copays, cost sharing,

out-of-pocket limits, and treatment limits must be the same for any behavioral disorders that the plan chooses to cover as they are for physical conditions.

However, plans can choose which disorders to cover; they are not required to cover the entire spectrum of illnesses identified by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. The law simply requires that if a plan does offer coverage for mental illness or substance abuse disorders, it must do so to the same extent as for physical healthcare.

The rules will take effect during annual plan renewals beginning on or after October 3 of this year. Most plans renew January 1, so a big surge in effort to adjust benefits, pricing, and networks will have to occur within the next two fiscal quarters. Large groups will likely have to start planning for parity immediately, especially if they have to coordinate claims data between their physical and behavioral healthcare benefits administrators.

Plans and employers that have voluntarily offered this coverage, and those in states that have already required versions of parity, have demonstrated that careful benefit design and management can prevent runaway costs and offer better patient care at the same time. And the law includes a cost-based exemption. If the new parity provisions raise the total costs of any group health plan by 2% or more in the first year (and 1% in following years), the plan can seek a one-year exemption. However, these cost increases are likely to be the exception rather than the rule.¹

AN OPPORTUNITY FOR EFFECTIVE INVESTMENT IN MENTAL HEALTH

The managed behavioral healthcare organizations (MBHOs) have generally succeeded in reining in the excessive spending that existed many years ago. But there are significant opportunities for additional improvement in mental health. Consider the following:

¹ Recent Milliman estimates put the industrywide cost impact of parity at 0.1% if health plans increase their utilization management (UM), and at 0.6% if plans continue with current levels of UM. These estimates don't consider the potential cost offsets from reduced demand for other health services once behavioral illnesses are treated.

- Diagnosable behavioral disorders are prevalent in about one in every four Americans in any given year.
- Nearly half of all Americans will meet criteria for a diagnosable behavioral disorder in their lifetime.
- Only 10% of those suffering from such disorders receive treatment from behavioral specialists; one-third seek treatment from primary care providers (PCPs), while the rest go untreated (although many seek treatment for physical symptoms of these disorders).
- Untreated behavioral disorders result in significant amounts of symptomatic treatment by PCPs. Depression first manifests as pain in 80% of cases, and many PCPs spend numerous office visits treating patients looking for symptomatic pain relief. There is a direct correlation between increasing numbers of physical symptoms and the likelihood of psychological disorders, and PCPs are ill-equipped to identify and treat these disorders.
- PCPs prescribe the vast majority of all psychotropic drugs, but such treatment is not even minimally effective in 87% of these treated cases (even though the proper use of psychotropic drugs can be highly effective).
- When behavioral disorders are comorbid with chronic or severe physical conditions, the costs of the physical conditions are greatly increased. Members with such comorbid conditions incur very large healthcare costs.
- When patients needing treatment get help from specialists, treatment effectiveness is greatly improved.
- New innovations in medical-behavioral integration, preventive care, lifestyle management, and proactive identification are showing great promise.

While limited behavioral healthcare benefits have historically been available in most benefit plans, the outcomes have been far from optimal. No one would argue that the results described above are desirable. They are largely a result of what we have created—an environment where behavioral conditions are still stigmatized, where cost and access hurdles exist for obtaining specialized treatment, where primary care treatment is regularly preferred yet ineffective, and where psychotropic drugs are overused and ineffectively managed.

The move to mental health parity coverage may very well present a great opportunity for positive change. An investment in more effective behavioral healthcare treatment is an opportunity to improve not only mental health but also physical health in our insured populations. Such health improvements can lead not only to lower healthcare costs, but also to improved productivity among employees.

EVIDENCE FOR CONSIDERATION

Many organizations, most notably the MBHOs, have effectively used some form of behavioral healthcare management guidelines to control unnecessary behavioral healthcare for many years. The application of medical necessity criteria to the new behavioral

healthcare benefits is allowed under the new rules. Milliman has recently added expanded, detailed behavioral health guidelines to our portfolio of detailed care guidelines, and they include inpatient acute care, residential care, partial hospital programs, intensive outpatient programs, and acute outpatient care. A broad spectrum of behavioral disorders has its own annotated, evidence-based guidelines. Effective use of such guidelines has been proven to control unnecessary behavioral healthcare. For example, savings in inpatient costs of 30% to 40% are often seen by MBHOs. The legislation permits such application of medical necessity criteria, even if done so more closely than physical healthcare.

Helping PCPs identify and treat behavioral disorders has also proven effective. Successful, non-traditional approaches include health plan payments for behavioral disorder screenings completed in primary care settings, on-site assistance from behavioral specialists, integrated medical-behavioral care management by nurses employed by health plans, and real-time video/teleconferencing with behavioral specialists. Returns on investment of up to 2.5 have been appearing for these programs.

Internet solutions are also emerging, complete with studies showing proven impact on reducing healthcare costs and improving productivity. Annual savings of thousands of dollars per participant are being reported by these Internet innovators.

WHAT'S RISKY OR UNCLEAR?

The new law includes some hard-to-define statements and does not spell out all the details. For example, the law defines parity as behavioral coverage that is “no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.” Clearly this will be subject to some uncertainty in interpretation.

Another issue that is unclear is the application of separate but equal calendar-year deductibles and out-of-pocket (OOP) limits for physical and behavioral healthcare. Can separate but equal deductibles and OOP limits exist? Or does a single deductible and OOP limit across medical and behavioral benefits need to be coordinated in the benefit administration? And how easy will that be for plans or employers that have not had to deal with it historically?

Then there is the design challenge of providing behavioral healthcare services that have no physical healthcare equivalent, such as partial hospital benefits. It is also not entirely clear how state laws are affected.

Perhaps the riskiest part of the change will be the required inclusion of out-of-network (OON) benefits where they are provided for physical healthcare benefits. Most preferred provider organizations (PPOs) will be affected. Previously, OON behavioral benefits could have been managed through specific benefit limits and payment caps—but not anymore. It will now be common to have unlimited OON behavioral benefits at payment levels such as 80% of usual and customary fees. This increase in OON benefit coverage could lead some providers to opt out of current networks (which have contracts at reduced fee levels) in favor of potential increases

in their fees that would occur under OON benefits. Additionally, certain providers, facilities, or programs that have been historically exclusively *private pay* may now end up as prestigious OON providers. We may even see an increase in direct-to-consumer advertising by some providers similar to what has occurred in the pharmaceutical industry.

START DESIGNING YOUR APPROACH

Whatever your view, the evidence is clear that adequate preparation centers around five interrelated focus areas:

- benefit design
- utilization management
- network formation
- pricing
- proactive or reactive approach

Benefit design

The law allows latitude in benefit design. Plans can choose to cover any combination of mental health and substance abuse disorders, including none at all. It is unlikely, however, that plans will find it advantageous to drop existing behavioral benefits rather than cover them at parity; not only would this alienate many customers and advocacy groups, but it would also ignore the premise that effectively treated behavioral disorders can reduce physical ailments in the medium- to long-term and raise productivity. Plans should start detailing their existing behavioral coverage now, take stock of their benefit utilization history by type of service, and think through how to redesign these benefits. In particular, they should determine how many people maxed out on their benefits previously, and more generally model the financial impact of the benefit plan change based on historical data—bearing in mind that any such analysis will be optimistic (on the low side) because demand for services will likely rise with better coverage under parity.

Plans should also review their employee assistance programs (EAPs) to get the best value from their combined EAP coverage and behavioral benefit coverage.

Utilization management

Some plans have chosen to let the limited benefit designs for behavioral benefits serve as a type of utilization management surrogate. Under parity, this approach obviously needs re-examination. The utilization management practices developed by MBHOs have helped establish a set of working guidelines that continues to evolve. These practices show how behavioral disorders can be covered without runaway costs and limitless treatment horizons. But offering the same services at full parity in these uncertain times may still be a challenge. Expanded coverage could raise incentives for overutilization of services, especially for out-of-network services. Plans should benchmark their historical benefit utilization with targets from behavioral care guidelines, including how different behavioral specialists can be used in networks and how various lower-cost step-down benefits are utilized within their healthcare systems.

Provider networks

Preparing for parity has major network capacity implications. First, is your current provider network big enough? Plans must consider not only the size, but also the composition—for example, the relative numbers of psychiatrists, psychologists, and social workers. The quality of the providers is also important; plans will want to find providers that are willing to work within their benefit design, utilization management, and pricing parameters. Plans must also take into account the location of the insured population relative to the availability of providers in the network. Rural and urban areas will offer very different options with respect to quantity, composition, and quality of providers.

Plans will have to take stock not only of the adequacy of their provider network, but also how they use it—how they provide access to specialists. Overreliance on PCPs can be a recipe for more repeat visits and higher costs. In the short run, plans may need to expand their specialist networks and educate their insured populations about their options.

In the long run, the industry as a whole needs to provide a more holistic approach. Plans should start thinking about getting behavioral care specialists involved in diagnosis and treatment in the primary care setting. This could be as simple as having a psychiatrist available on a consulting basis or employing an on-site psychiatric nurse.

Pricing

Finding the right pricing approach for behavioral coverage will be especially tricky in a recession. Anxiety and depression tend to rise, resulting in increased utilization and costs. Parity pricing should incorporate the possibility of increases in prevalence rates of behavioral disorders. Plans should review not only the expected costs of specialty behavioral healthcare benefits, but also other sources of behavioral condition treatment, such as primary care settings and their patterns of psychotropic drug use. In effect, plans will need to consider the interrelationship of benefits and costs across physical and behavioral services.

For example, new consumer-driven health plans and high-deductible plans could result in reduced utilization of mental health services if consumers are either unaware of their behavioral disorder or elect to defer treatment for any of a number of reasons. These plans can create incentives for patients to defer early treatment for seemingly small problems that can develop into something far worse down the road.

The ability to contract with behavioral specialty providers will have an impact on pricing. Managed behavioral healthcare, wellness, and disease management companies have considerable experience contracting with behavioral healthcare specialists. Some firms will find it easier to maintain or develop a contractual relationship with such an organization and rely on their expertise. Others may want to develop this function internally.

An important consideration for pricing increased mental health benefits is the ability of the healthcare delivery and management

STEPS THAT HEALTH PLANS SHOULD TAKE TODAY TO PREPARE FOR PARITY

- Review the history of mental health care coverage patterns. Effective bargaining and utilization management have led to falling costs. The current challenge is to integrate mental and physical care in a comprehensive way that continues to reduce costs and improve outcomes.
- Assess your plan's individual risk exposure from this change. Chances are it's not as bad as you think. Emerging research indicates that there can be a positive return on investment to integrating physical and behavioral care, especially for patients with comorbidities.
- Inventory your own plan's history with behavioral care. What are you really spending on behavioral care today? Which illnesses are you covering or have you considered covering in the past? How will this change under different coverage scenarios?
- Inventory the utilization history of your insured population for the relevant categories of care (i.e., prescription drugs, therapist visits, etc.). This will help in setting benchmarks, and you may find that expanded coverage could even be good for your plan if behavioral benefits are provided more effectively and are better managed.
- Examine your plan's provider network and consider whether it is the right size and composition to offer the services you are considering under your expected benefit design, utilization management plan, and pricing structure.
- Consider your contractual relationships. Do you want to outsource these services to a managed behavioral healthcare organization, integrate with such a group, or provide the services in-house? Do you have the expertise to contract with behavioral specialty providers?
- Keep in mind that in the long run, costs can be best kept in check by integrating the treatment of the body and the mind so that ailments missed in one area don't pop up in another.

system to do its job effectively, such that those in need of treatment achieve healthy outcomes, with the prospect of reduced medical costs and increased productivity.

Proactive or reactive approach

Health plans should take immediate steps to prepare for these changes, but may choose to do so with a proactive long-run view of how to optimize this new portfolio of services. Potential cost increases will have to be managed, but gains can be realized along a number of margins. There may be significant opportunities for reducing total healthcare costs by incorporating an integrated medical-behavioral healthcare approach into the health plan. The magnitude of the intrinsic returns to treating the mind and the body together and avoiding negative synergies between comorbid physical and mental illnesses continues to emerge. Evidence has clearly shown that in patients with certain comorbidities such as diabetes and depression, providing proactive and effective specialized mental health services can be very cost-effective by raising a patient's willingness to adhere to prescribed physical treatments for their chronic medical condition, avoiding the deterioration in physical health that commonly occurs for these cases.

Employers also stand to benefit from improved productivity and reduced sick days and disabilities, and may also need to be educated that parity doesn't necessarily mean runaway costs.

And the populace at large should benefit from a more whole-patient approach to mental health. While the transition may be at times difficult for employers, health plans, and MBHOs, it also offers an opportunity to shore up a weakness in the overall healthcare system.

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