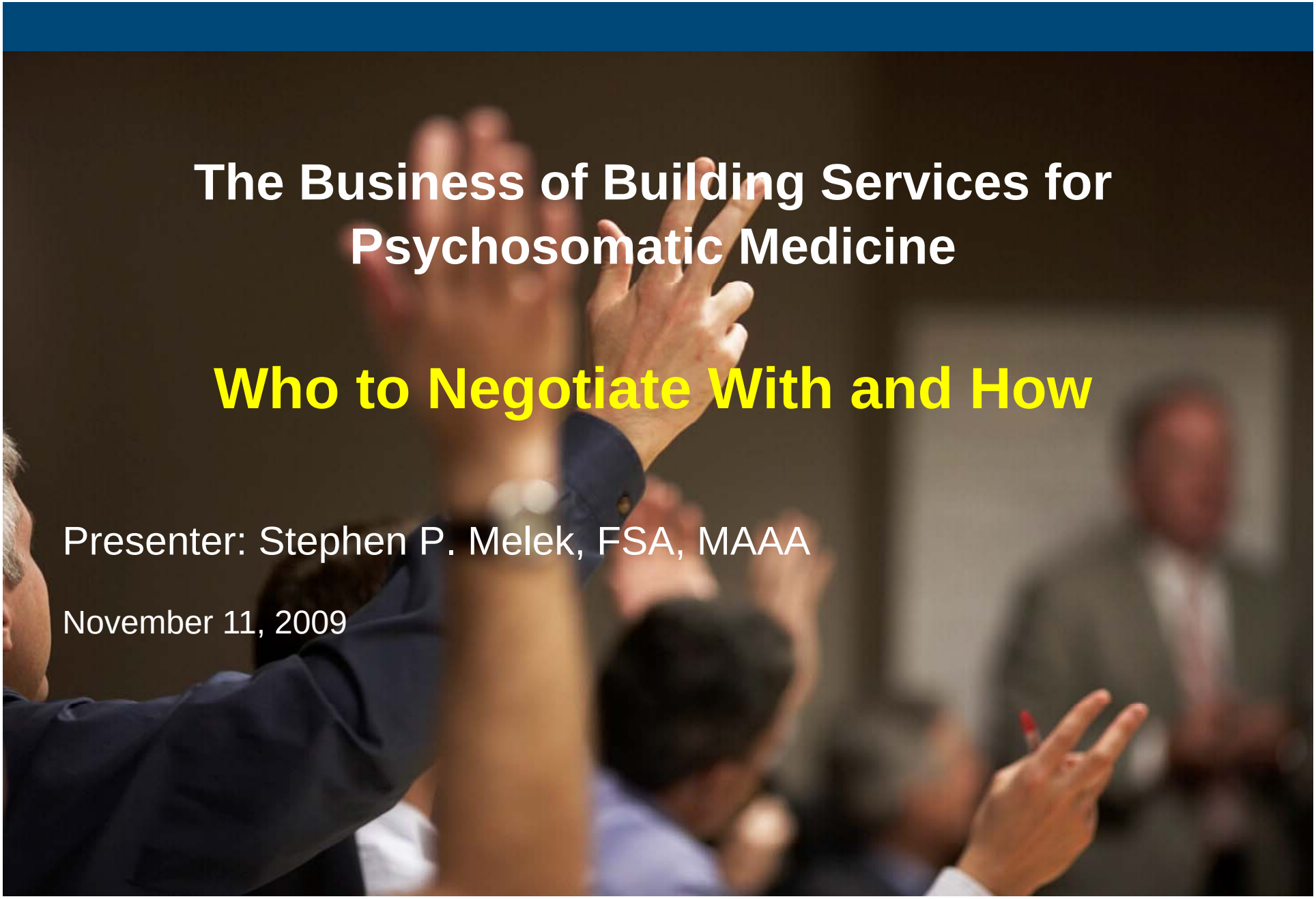


The Business of Building Services for Psychosomatic Medicine

Who to Negotiate With and How

Presenter: Stephen P. Melek, FSA, MAAA

November 11, 2009

Milliman

Disclosure: Steve Melek, FSA, MAAA

Milliman
Employment--Direct Relationship
Consulting--Direct Relationship

Outline

- Some History – Prevalence and Spending
- Changes Coming – Federal Parity Requirement
- Opportunities for Improvement
- Getting to Yes

Mental Health Facts

Prevalence of Behavioral Disorders in the general US population: 30% for years, some are mild and below threshold levels

100 Adults

22 with diagnosable mental disorder

2-3 will seek treatment from mental health specialists

5-6 will seek some type of treatment in primary care settings, and 14-15 will go untreated

Source: Kessler, et.al. 2005

Depression Facts

- Affects 9.5% of the population in any given year
- 1 in 6 individuals will be affected by depression at some point in their lifetime.
- According to the World Health Organization, the incidence of depression is expected to increase.
- Average delay between onset of illness and treatment is 6-8 years

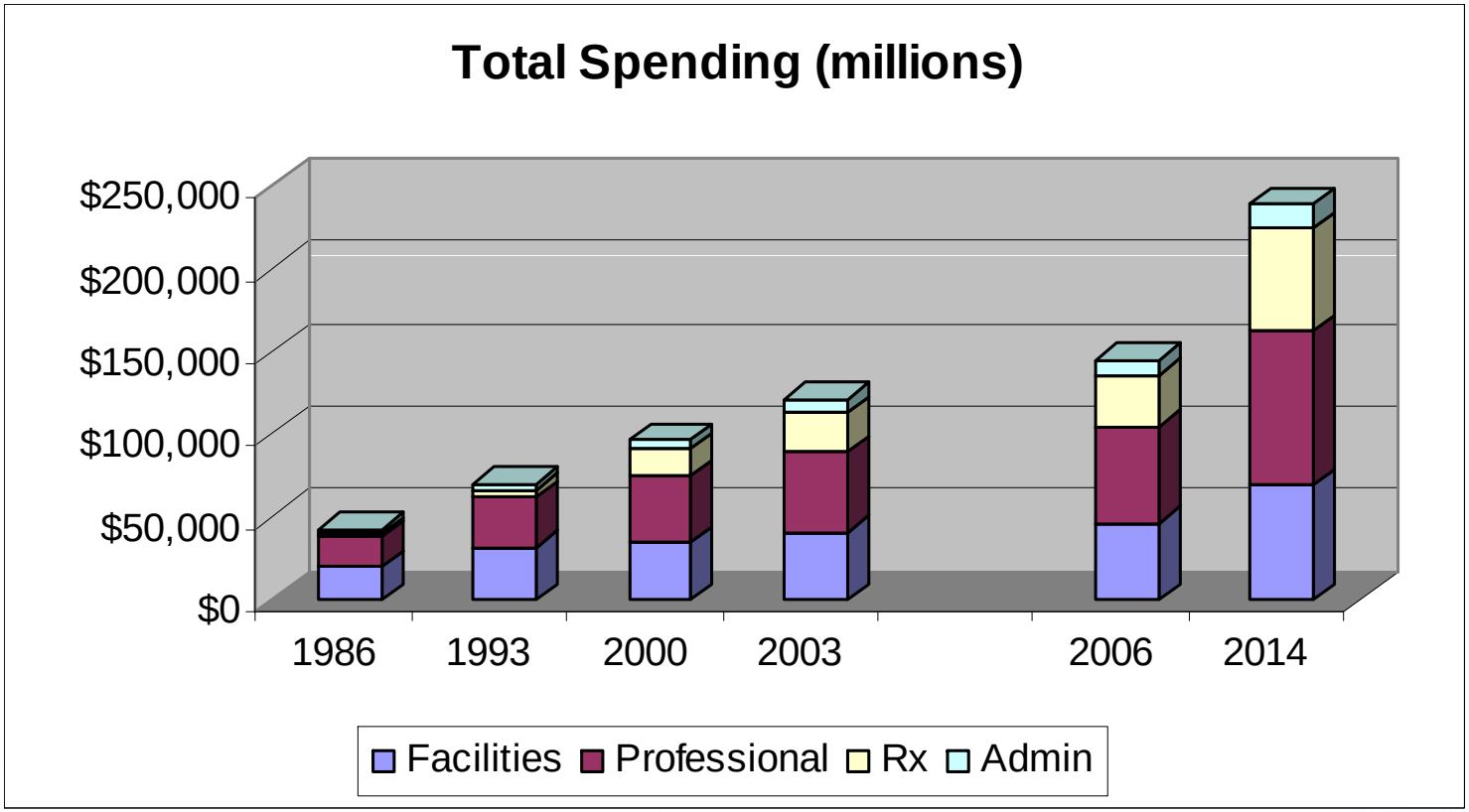
Behavioral Healthcare Spending

Private Insurance - Mental Health and Substance Abuse Expenditures

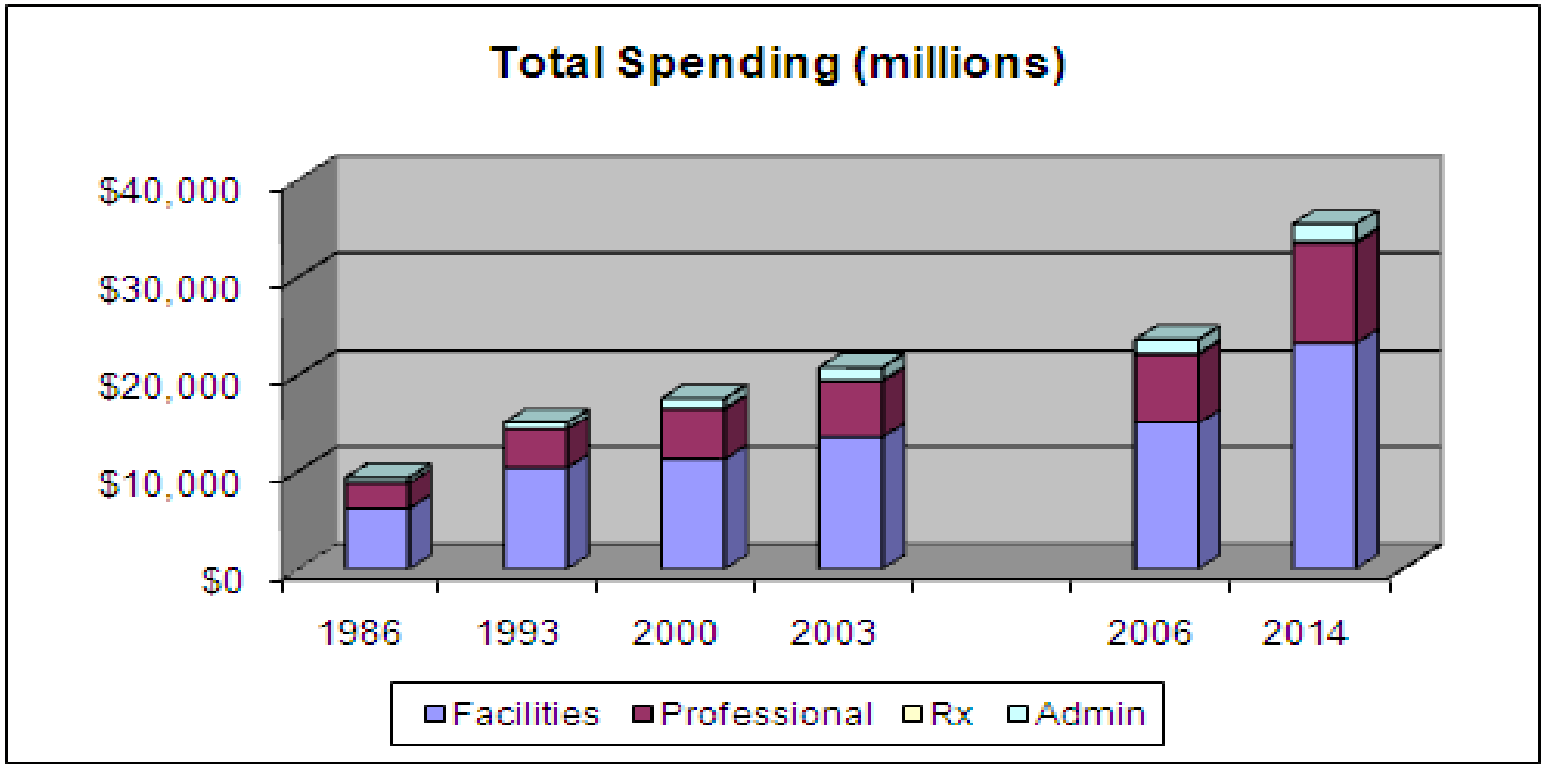
1986 - $ 7.1 billion vs. $2.8 B
2000 - $17.4 billion vs. $1.9 B
Proj. 2006 - $ 29.7 billion vs. $2.1 B
Proj. 2014 - $ 53.6 billion vs. $2.4 B

Source: SAMHSA Spending Projections, 2007

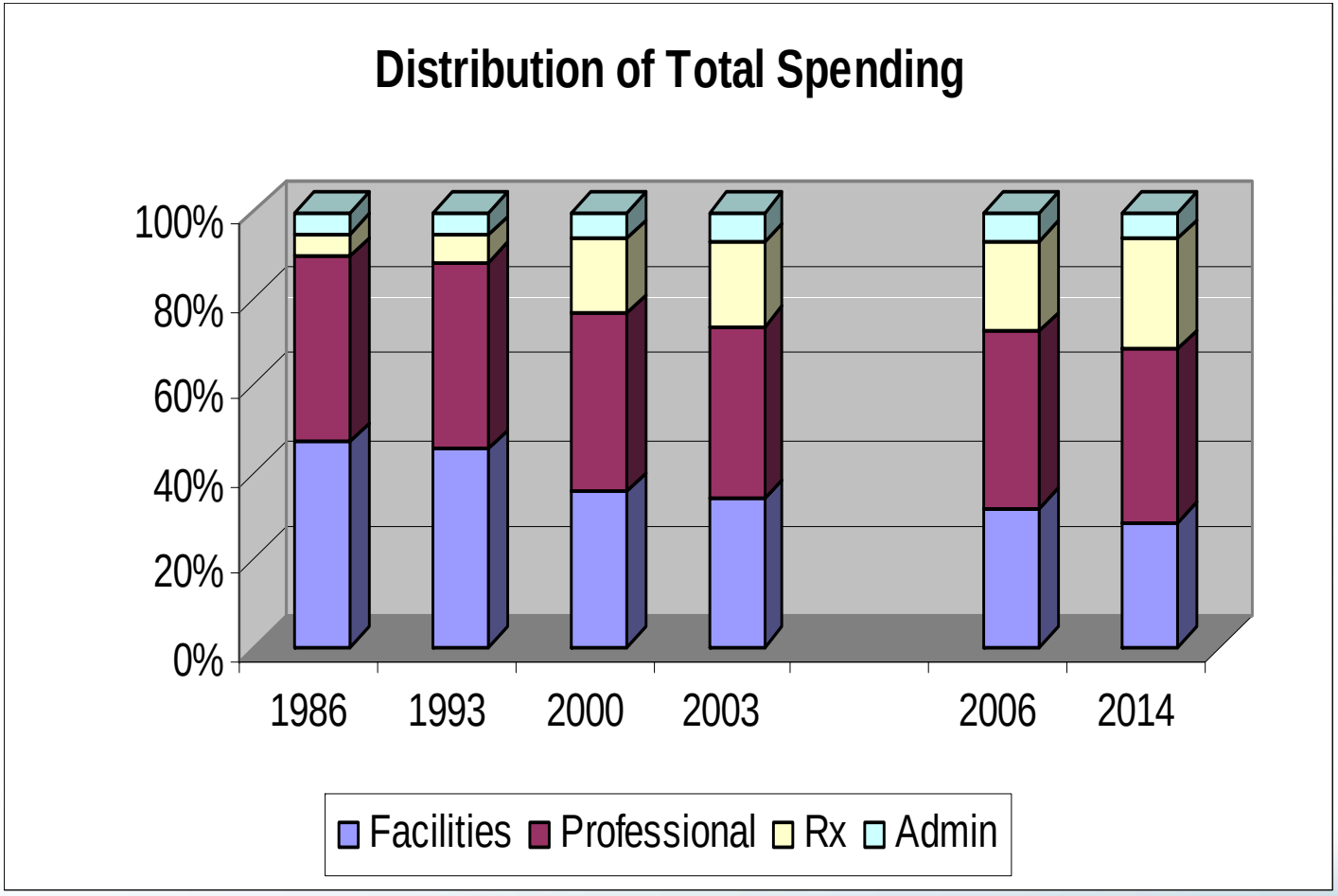
Total Behavioral Healthcare Spending – All Payers



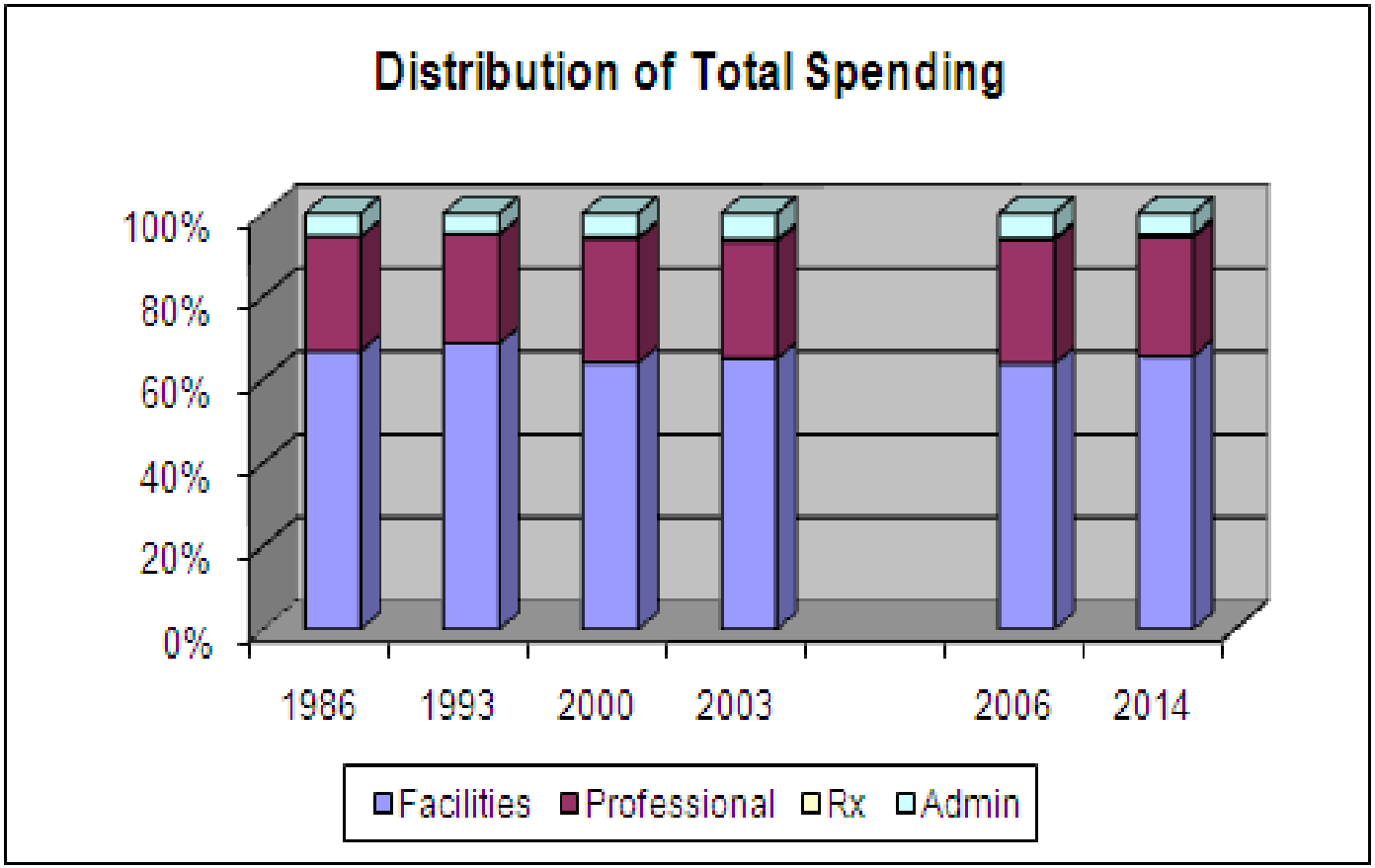
Total Substance Abuse Treatment Spending – All Payers



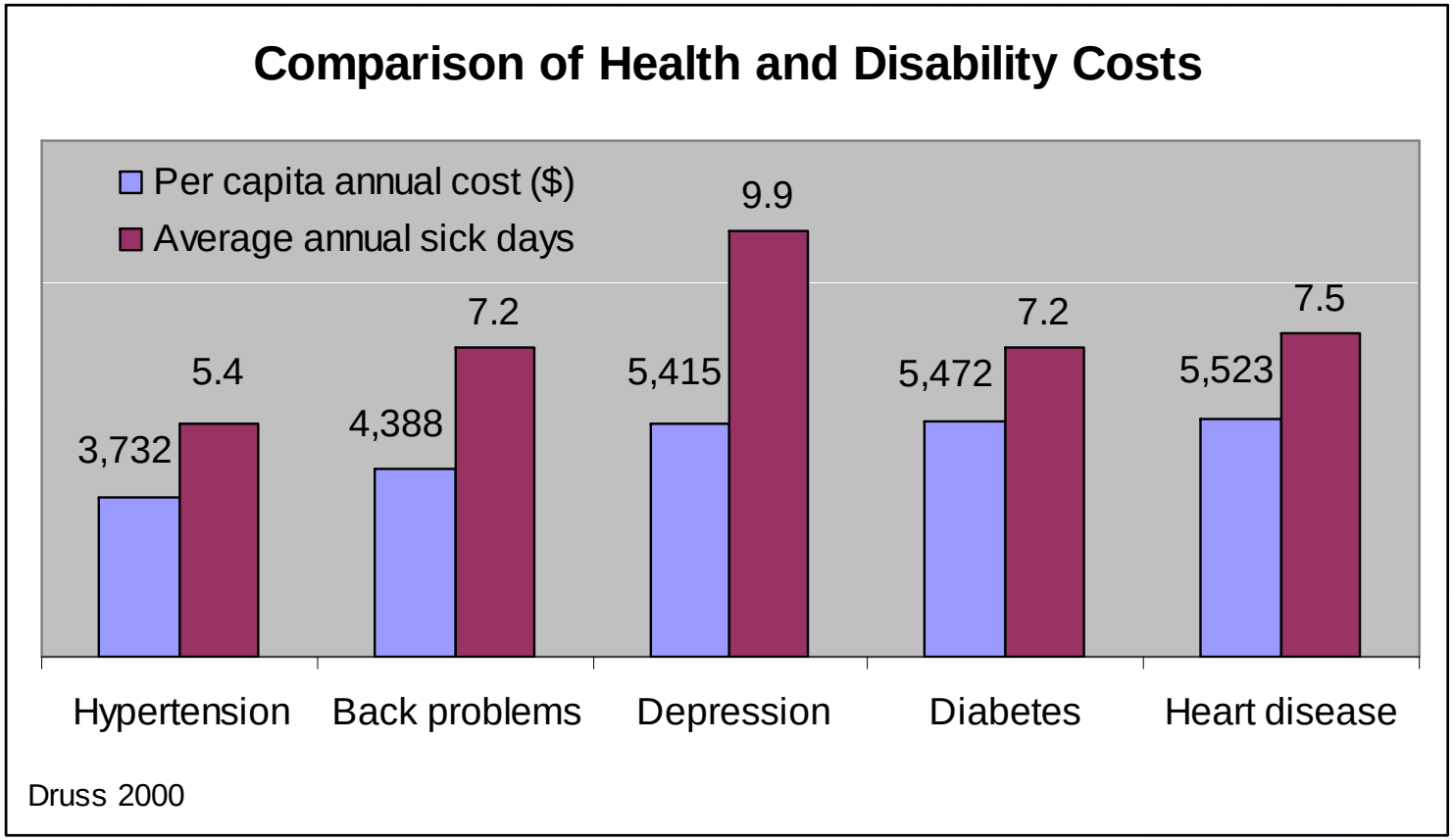
Total Behavioral Healthcare Spending – All Payers



Total Substance Abuse Spending – All Payers



Health and Disability Costs of Depression



Economic Burden

Based on average impairment and prevalence estimates, depression and other mental illness ranked 3rd for the overall economic burden of illness among the top 10 health conditions, at an average annual cost per employee of $348, behind hypertension ($392) and heart disease ($368)

Source: Goetzel et.al., JOEM, April 2004

The Quality of Treatment

- Minimally Adequate Treatment of Behavioral Disorders:

  48% of those treated in MH setting (35% SA)

  13% of those treated in Medical setting (5% SA)

  => 8% of all members with prevalent disorders

- In spite of effective treatments and evidence-based guidelines, only 1 in 5 individuals with depression **who seek treatment** are treated according to minimum standards (JAMA, 2003).

Primary Care Issues

- 25-36% of primary care patients have a diagnosable behavioral disorder
- Behavioral disorders often present with physical symptoms such as fatigue, chest pain, dyspnea, low back pain, etc. (80% of individuals eventually diagnosed with depression complain of physical pain first)
- PCPs not well-trained in BH may focus on the physical symptom and overlook the underlying behavioral disorder.

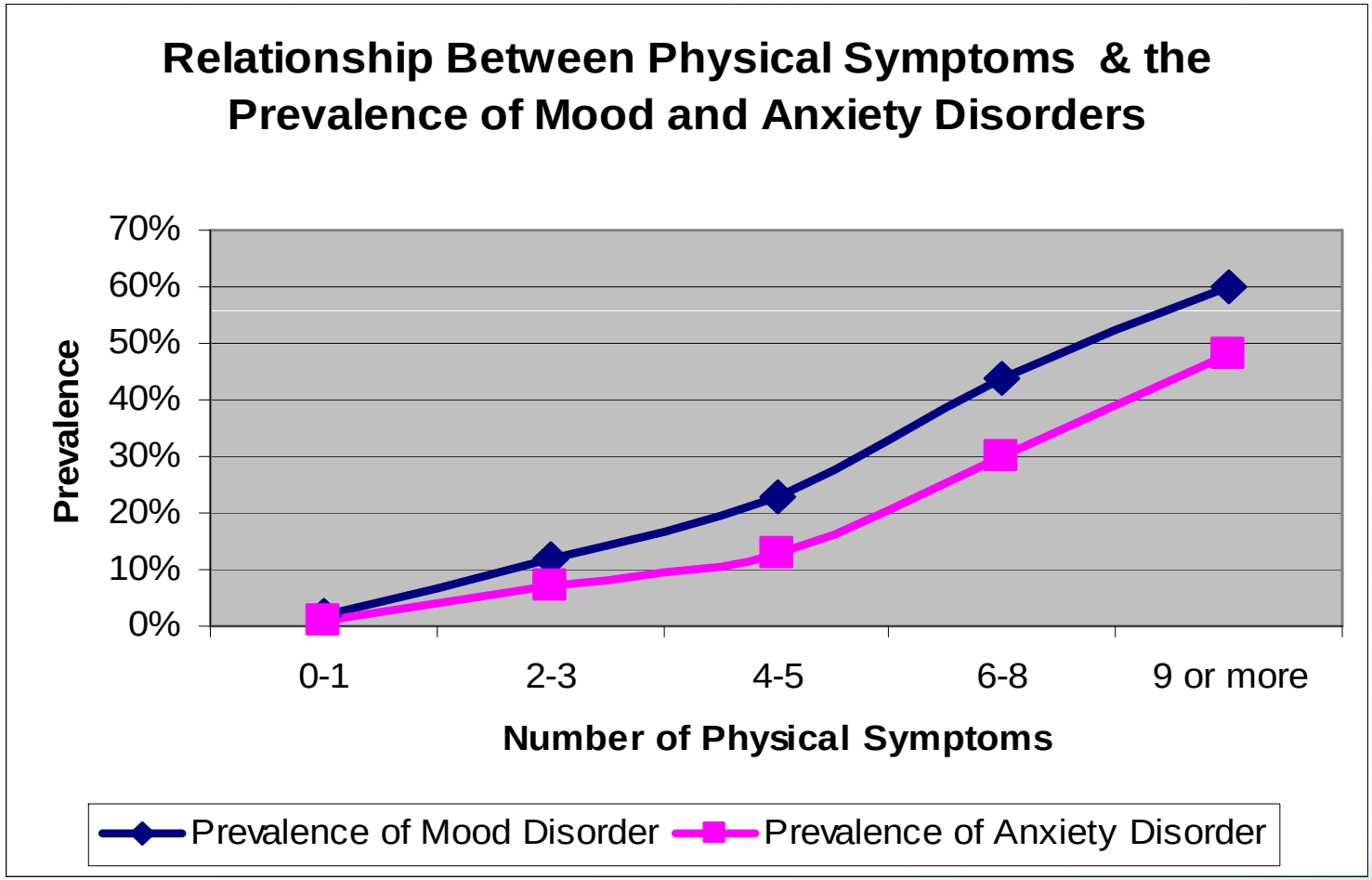
Psychotropic Drugs – Effectively Used?

Types of Challenges with PCPs Prescribing Psychotropics

- Low Patient Adherence Rates
- Sub-Optimal Dosing
- Therapeutic Duplication
- Impact of Side Effects
- Inappropriate Use
- Poly-pharmacy
- Contraindicated Use

Physical Symptoms & Psych Disorders

(Kroenke, 2003)



Along Comes Healthcare Reform

- HR1424 – The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008
- What does it cover?
- What doesn't it do?
- What is unclear?
- When will things be clarified?
- Is this an opportunity?

HR1424 – Some Details

- Amends the Mental Health Parity Act of 1996
- Applies to group health plan of > 50 employees
- If plans provide mental health or substance use benefits, they must have financial requirements and treatment limitations applicable to mental health/substance use disorder benefits that are no more restrictive than those requirements and limitations placed on medical/surgical benefits.
- Equity coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.

HR1424 – More Details

- If a plan offers two or more benefit packages, the requirements of this Act will be applied separately to each package
- As under the current Federal parity law, mental health or substance use benefit coverage is not mandated
- Effective for plan renewals on or after 10/3/09
- A group health plan (or coverage) that provides out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits
- As under the 1996 Mental Health Parity Act, a group health plan (or coverage) may manage the benefits under the terms and conditions of the plan

HR1424 – More Details

- The current HIPAA preemption standard applies. This standard is extremely protective of State law. Only a State law that “prevents the application” of this Act will be preempted which means that stronger State parity and other consumer protection laws remain in place.
- If a group health plan (or coverage) experiences an increase in actual total costs with respect to medical/surgical and mental health/substance use benefits of 1% (2% in the first plan year that this Act is applicable), the plan can be exempted from the law

HR1424 – Cost Estimates

- Milliman projected an average increase of 0.6% in total healthcare costs from parity with no changes in utilization and care management – this translates to $2.40 pmpm or close to $30 million for every 1 million insured lives

- We also projected that this cost increase could be managed to <0.1% with improvements in utilization and care management

- These estimates exclude potential savings from medical cost offsets when members receive effective treatment for behavioral disorders

Some Out-of-Network Considerations

- Co-morbid Patients Will Eat Through Out-of-Pocket Limits
- Sample Plan Design: $1,000 deductible + $1,000 INN Coinsurance Limit + $2,500 OON Coinsurance Limit, with 80% INN coverage, 60% OON coverage
- Hits OOP Limit INN at $6,000 of allowed charges; hits OOP Limit OON at $7,250 of allowed charges
- 2008 Annual Probability of exceeding $6,000 of Undiscounted Charges: 22.2%
- 2008 Annual Probability of exceeding $7,250 of Undiscounted Charges: 19.7%

2010 HCGs – Preliminary PMPM Costs under Parity

(all payers, typical benefits - undiscounted)

Specialty Behavioral	Loosely Managed	Tightly Managed
Inpatient Hospital	$5.25	$1.83
Outpatient Hospital	1.66	0.71
Inpatient Professional	0.59	0.18
Outpatient Professional	9.23	2.70
Total Behavioral	**$16.73**	**$5.42**
Psych Drugs		
Professional Office/Urgent Care Visits	$34.45	$25.35
All psychotropic classes	$16.27	$7.45

Prevalence of Co-morbid Depression or Anxiety among Chronic Conditions

Commercial Population	1. Disease Prevalence Rates		2. Co-morbid Prevalence Rates	
Chronic Medical Condition	Scientific	Treatment	Scientific	Treatment
Diabetes Mellitus	7.0%	5.2%	29.0%	24.8%
Hypertension	16.1%	9.1%	28.0%	24.7%
Arthritis	14.1%	7.9%	30.0%	25.9%
Asthma	6.6%	2.4%	54.0%	19.5%
COPD	3.8%	1.4%	37.0%	30.5%

What's the cost impact of comorbid depression on a patient with a chronic medical condition?

Impact of Co-morbid Psych Illness with Chronic Medical Conditions on PMPM Costs

Chronic Medical Condition	*With Comorbid Depression Treatment*	*No Comorbid Depression Treatment*
Diabetes	$1,182 (108)	$ 701 (10)
Hypertension	$ 961 (98)	$ 550 (9)
Arthritis	$1,048 (122)	$ 521 (12)
Asthma	$1,065 (125)	$ 399 (9)
COPD	$1,377 (133)	$ 713 (14)
	Total Healthcare Cost PMPM (Behavioral Cost)	

An Opportunity to Invest in Mental Health?

- Improve access to specialists that are effective
- Better outcomes for complex behavioral patients
- Improve health of comorbid patients, reduce total healthcare costs
- Reduce costs of somatic complaints, burden on PCPs
- Increase effectiveness of psychotropic treatments
- Increase employee productivity
- Reduce absenteeism/disability costs

Projected Annual Cost of Status Quo
Commercially Insured Population

	Treatment Comorbidity	Expected Comorbidity
Commercially Insured Population:	218,000,000	
Comorbid Chronic Medical-Psych:	6.39%	18.43%
Comorbid Cases:	13,900,000	40,200,000
Average Cost Increase PDMPM:	$ 500.00	$ 500.00
Annual Comorbid Cost:	$ 83,400,000,000	$ 241,200,000,000

Projected Annual Cost of Status Quo Medicare Population

	Treatment Comorbidity	Expected Comorbidity
Medicare Insured Population:	39,200,000	
Comorbid Chronic Medical-Psych:	20.81%	46.79%
Comorbid Cases:	8,200,000	18,300,000
Average Cost Increase PDMPM:	$ 500.00	$ 500.00
Annual Comorbid Cost:	$ 49,200,000,000	$ 109,800,000,000
Combined Cost:	$ 132,600,000,000	$ 351,000,000,000
Impact of each 10% Gap Closure:	$ 13,260,000,000	$ 35,100,000,000

Long Term Projected Cost of Status Quo

10 year total:	$2,350 Trillion
20 year total:	$9,778 Trillion

So …Who Do I Negotiate With?

- Health Plans – they have the most opportunity for healthcare cost savings
- Employers – they have the most opportunity for reduced costs and productivity gains
- Medical Centers – they have opportunities for increases in admissions from lower ALOS, decreases in 1-on-1 care, reduced liability for adverse MH/SUD-related events in medical settings
- Non-psychiatric physician groups – improves clinical outcomes, possible shared savings, improvements in capitated arrangements
- MBHOs - ???

Impact on Contracted Fees

- 90862 Med Mgt Check – Current common contracted fees with MBHOs => $45 - $50 per visit
- Extrapolation of Commercial Managed Care fee schedule at 125% of Medicare Allowed for 90862 => $65 - $70 per visit
- 99252 IP Consult – Current common contracted fees with MBHOs => $75 - $80 per visit
- Extrapolation of Commercial Managed Care fee schedule at 125% of Medicare Allowed for 99252 => $95 - $100 per visit

Impact on OP Visit Volume

- 1 million commercially insured members

  Moderately managed => 72,000 medical/evaluation/meds visits

  Additionally => 1,760,000 office visits to PCPs

  ……if 25% have underlying behavioral disorders

  that's 440,000 office visits that could benefit from Psych MDs,

  ….a 6-fold increase in Psychiatric touches

Integrated Medical-Behavioral Healthcare
A Case Study

A Major Health Plan had designed an Integrated Medical-Behavioral Care Management Program and needed help with 2 key items:

1. Was the program meeting ROI objectives?
2. How could members that resulted in the best outcomes be identified through predictive models?

An Integrated Medical-Behavioral Care Management Program is Born

- HRAs on new members
- Member responses to questions trigger referral
- Medical and Behavioral care manager team
- Engagement effort
- Goals set for participants
- Graduation upon achievement

Why a Predictive Model?

- Referrals vary
  - Participants who graduate
  - Participants who have long “active” periods
  - Participants who dropout
  - Members who refuse
  - Members not able to be contacted

- Effective Engagement
  - members who change behavior and get healthier
  - members who do not change and cost $$

Why a Predictive Model?

A Capacity Problem

- 1 million insured members
- 20% treatment co-morbidity = 200,000 IMBH candidates
- Nurse shortages => staffing challenge
- Target participants of 10,000

Data Available

- HRA Data
- Detailed claim data
  - medical claims
  - behavioral claims
  - pharmacy claims
- Demographic data (eligibility)
- Consumer Data

Consumer Data

- Favorite Interests
- Healthy/unhealthy habits
- Physical activity
- Support system
- Socioeconomic status

Treating the Top 2%

Milliman 2009 Healthcare Cost Estimates		
Top %	Average Cost	% of Total
1%	$ 195,520	29.5%
2%	$ 139,755	37.9%
5%	$ 78,360	54.4%
10%	$ 50,890	68.0%

Treating the Top 2%

From every 1 million lives => 20,000 High Cost People

At 95% effective coverage => $2.65 Billion

With 60% having MH/SUD => $1.59 Billion

With only ~10% of these effectively treated => $1.45 Billion Cost

Can we reduce costs by 5% through improved outcomes?

If so => $72 million saved = 1% of total healthcare costs