The GAME CHANGER for Behavioral Health Costs under Mental Health Parity

By Fred Newman

When Congress passed the Mental Health Parity and Addiction Equity Act of 2008 (parity), most "experts" looked at past utilization and costs for mental health (M/H) claims, which are relatively low, and projected a minimal cost impact from expanded parity benefits. In their assessment and projections of parity, most failed to recognize three important issues relating to the quality and scope of mental health treatment as health plans move forward under parity.

First – the majority of patients seeking mental health care today are doing so in the general medical setting.

Second – M/H and substance abuse treatment facilities have been relatively silent regarding any direct consumer marketing for almost 20 years.

Third – most utilization management for M/H treatment is designed to manage care only when a higher level of treatment is indicated.

The above three issues together will create the "game changer" that increases utilization and costs for M/H claims under parity benefits. Employers must evaluate their future exposure and implement programs to manage the resulting risks. There are two choices available – realize the future impact now and adopt a proactive and comprehensive approach to minimize the risks, or wait for their costs to actually increase before reacting.

As stated above, most "experts" (TPAs, brokers, actuaries, etc.) failed to recognize that the majority of health plan members seeking mental health care are doing so in the general medical setting with no mental health diagnosis. These plan members were not calculated to impact M/H claims under parity. At first, this may not seem to be a problem. But, if one realizes, as many studies have reported, most general medical providers have neither the time nor training to properly treat mental health issues, then the problem is defined.

For most individuals seeking M/H care in the general medical setting, the following clinically accepted guidelines are not being followed:

- Quality assessments of mental health problems
- Ongoing screenings to evaluate the effectiveness of treatments
- Medication management to determine the most effective drug and/or dosage
- Medication monitoring to ensure drug compliance
- Patient education regarding treatment and compliance

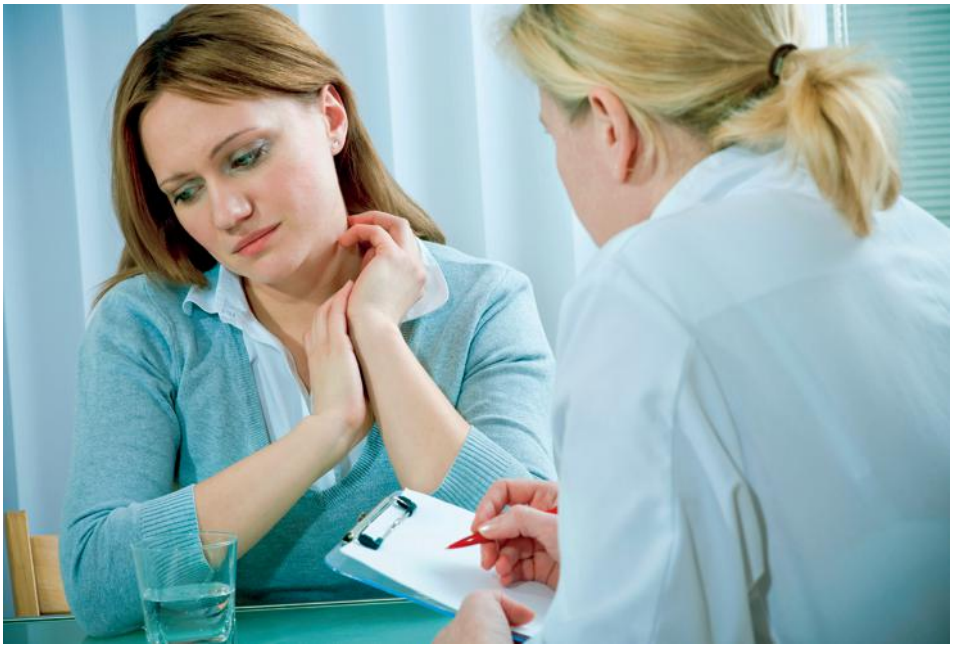
- Psychotherapy for those dealing with mental health stressors
- Feedback to patients regarding change in their condition

So how are general medical doctors treating M/H conditions? They are prescribing an antidepressant or other psychotropic drug during a general office visit without applying most or any of the above listed clinical guidelines. Per IMS Health, antidepressants alone have been in the top four classes of prescription drugs in the U.S. over the past five years. Around 80 percent of antidepressants and certain other psychotropic drugs are written by general medical providers. Numerous studies and reviews have presented evidence documenting significant quality of care issues around mental health treatment in the general medical setting. In fact, the Interim Final Rules (for the parity act) presented a study that found only 12.7 percent of individuals seeking mental health treatment in the general medical setting received minimally adequate care.

As far as the number of health plan members impacted, most employers are experiencing between 10 and 25 percent of their members as having filled a script in a recent 12-month period for a subgroup of psychotropic drugs that are primarily prescribed in the general medical setting. This subgroup includes antidepressants, anxiolytics, and sleep-aids. Again, these members are not showing up as mental health claims under the health plan. In fact, most health plans are currently spending more on this subgroup of psychotropic drugs (prescribed by general medical doctors) than they are on treatment from mental health providers.

As we move past plan renewals with parity benefits adopted by most employers, a number of treatment facilities will begin direct consumer marketing. It worked in the eighties for treatment facilities, continues to work today for pharmaceutical companies, and will certainly be effective in the future under parity benefits. This will put in play the "game changer" for mental health claims going forward.

To minimize this problem, health plans need to implement proactive programs to identify members dealing with M/H conditions and coordinate effective care early-on. It is a clinical fact that if not appropriately treated, depression will likely worsen and become more treatment resistant. Studies report that when depression is diagnosed and properly treated within the first six months, the chance of achieving remission is greater than 50 percent. If depression is not properly treated for one year, the chance of remission drops to less than 20 percent. Bottom line, not treating mental health issues timely will create more plan members that meet medical necessity for higher levels of care later.



This brings us back to the impact that direct consumer marketing will have. There will be an increase in the number of "at-risk" plan members susceptible to the marketing of treatment facilities if not appropriately treated early-on.

To identify those plan members seeking mental health care in the general medical setting, one must filter the prescription drug data targeting certain psychotropic drugs. Then, a process needs to be implemented that coordinates the following:

- A two-way secure data feed to the pharmacy benefit manager (PBM) to exchange drug and compliance information
- Effective outreach to potential candidates based on filtering of drug data
- Financial incentives involving drug co-pays to encourage participation
- Telephonic screenings to determine candidates for participation
- Daily electronic reporting of compliance/noncompliance to the PBM
- Outreach and partnering with prescribing physicians to improve standards of care and treatment outcomes
- Ongoing standardized screenings completed with all participants to score and measure change in the severity of their symptoms (frequency based on severity)
- Monitoring of drug compliance through ongoing reviews of drug data
- Results of standardized screenings provided to participants and physicians
- Educational materials provided to participants so they better understand the conditions for which they are being treated, including the need for medication compliance during treatment
- Recommendations to treating physicians and participants around med-management and other treatment modifications based on screening outcomes, drug compliance, and treatment history
- Coordination with the EAP for free short-term psychotherapy when appropriate
- Outcome reporting on quality improvement

The need for the above process is amplified by a lack of psychiatrists to treat all individuals impacted with mental health conditions, which has been documented in numerous studies. So, one must figure out how to work within the general medical setting to improve standards of care for M/H treatment whereby outcomes for the majority of patients are dramatically improved.

Conversely, those individuals dealing with more severe M/H issues need to be under true care management. Utilization Management (UM) for M/H must be focused on managing and coordinating all aspects of care utilizing a step-down approach to ensure that each patient has in place the resources to minimize relapse. Medical based UM for M/H can no longer be focused on just moving the patient below a certain level of treatment with the mind set that "our job is then done" once that lower level of care is achieved. Specialized UM by mental health vendors must be utilized to achieve true care management. Otherwise, health plans will be incurring multiple episodes of treatment from facilities as patients relapse and meet medical necessity for readmission (with no benefit limitations in place to prevent it).

Analysis of these issues makes it clear that the basis for a "perfect storm" is in place regarding increased M/H claims costs for health plans under parity benefits. If you doubt it, then review the number of health plan members that have filled a prescription for a psychotropic drug in a recent 12-month period and compare that to mental health claims filed for the same time period.

Do employers take a proactive position to mitigate costs and improve employee health or just sit back and wait for their claims costs to increase while productivity decreases? ■

Fred Newman is the founder and CEO of Interface EAP and Coordinated Health Solutions. In the mid-eighties he was the CFO of a public company that owned and managed psychiatric hospitals. It was in this position that he saw the need for a behavioral healthcare company with a proactive approach for addressing the impact mental health has on medical costs, productivity, and other labor costs.

Fred founded Interface EAP in 1989, which began providing services on a national scale in 1990. In 2004, Interface began development of its unique Pharmacy Intervention Protocol (PIP) patent

pending to address the quality of care and costs issues resulting from the high use of antidepressants and other target psychotropic medications within the general medical setting. In 2009, Coordinated Heath Solutions was established to coordinate PIP with other EAPs.

Fred has previously served for four plus years on the board of the Texas Association of Benefit Administrators (TABA) and the Benefits Committee for the Self Insurance Institute of America (SIIA). He currently serves on the board for Mental Health America of Texas. He has presented programs on behavioral healthcare management to numerous groups including Benefit Management Forum & Expo, SPBA, TABA, WorldatWork, SIIA, URAC, Pharmacy Benefit Management Institute (PBMI), Health Action Council of Ohio, Midwest Business Group on Health, and Health Care Administrators Association (HCAA). In addition, he has authored several articles for industry publications including The Self-Insurer, The Journal of Employee Assistance, and TABA's The Benefit.