Managed Care:
Implications for Best Practice

presented by

James T. Wrich

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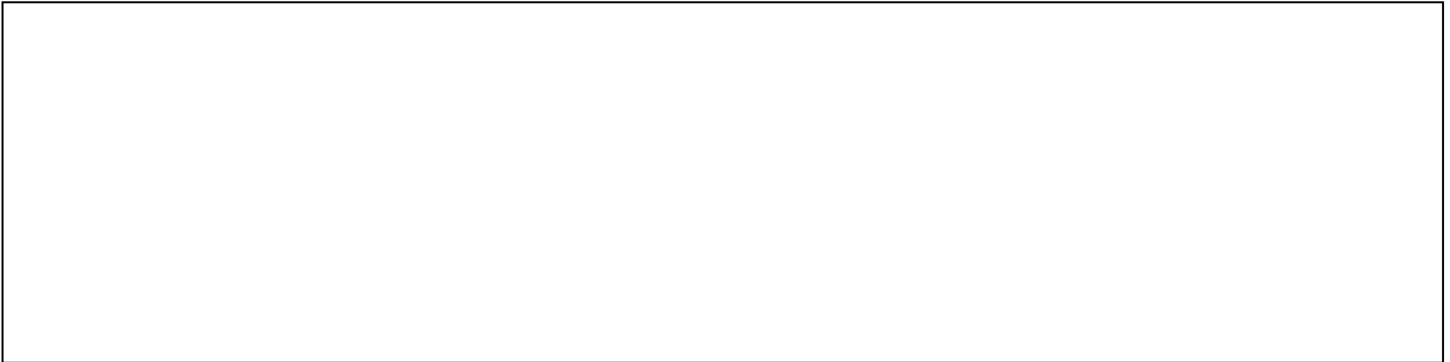
PRESENTATION OUTLINE

- **Ethical Considerations.**
- **How Managed Care Came Into Existence.**
- **How Managed Behavioral Health Care Operates.**
- **How Managed Behavioral Health Care Impacts Providers, Patients and Payors.**
    - **What We Can Do About It – Practical Action, Attainable Goals.**



I. Ethical Considerations.

- **The Mom Test**

  "If you mother knew what you were doing, would she approve?"

- **The T.V. Test**

  "What if *60 Minutes* aired what you are doing?"

- **The Smell Test**

  "Does it feel right to you? More, specifically, how does it smell?

II. How Managed Care Came Into Existence.

"Content without context is pretext." Warren Benis

- **Background**
- **The business model of health care**
- **History**
- **The basic operating principle**
- **Indemnity delivery requirements**
- **HMOs**
- **Anti-selection**
- **Mental Health/Chemical Dependency Treatment and EAPs**
- **The Fundamental Question: "What business are we really in?"**

- ***THE BUSINESS MODEL OF HEALTH INSURANCE***

It is almost a misnomer to refer to the system that delivers medical and mental health services in the United States as a health care industry. In reality, what we have is a very large health care sub-division of a huge financial services industry. When viewing insurance and HMOs from the perspective of finance and money versus what would constitute clinically sound care, what often seems like a cloudy picture becomes much more clear and less confusing.

As currently delivered, health care in the United States costs about $1.5 trillion annually. While hospitals, doctors and other individual practitioners represent a large portion of this expense, managed care providers (MCOs), HMOs and insurance companies, are consuming significant amounts for administration and profit under the guise of containing health care costs. Moreover, it can be argued that they are hardly fulfilling their primary mandate which was to control costs. As a multiple of inflation health care costs are rising faster now than in the mid 1980s when the country became so alarmed about rising health care costs that it virtually turned the health delivery system over to the HMOs. Sadly, the percentage of premium actually expended on direct care is dwindling, particularly in the area of mental health. Given the financial interests of the MCOs, HMOs, and insurance companies, whose administrative loadings, profits, cash flow and float depends on the current high level of expenditures, it is naïve to believe that they will do anything to significantly reduce overall costs. It is not in their self interest. They benefit from the current situation.

Managed care companies, whether they are medical HMOs or managed behavioral health firms, purport to assume and manage risk. But risk implies that there is a chance they can loose. In reality, this is rarely the case. The control factors in “at risk” contracts, whether medical surgical or behavioral health, are considerable. The MCOs control initial access, placement regarding type of care, level of care and length of care, and the fees providers are allowed to charge. Audits show that on the behavioral health side, generally, less than 50 percent of the premium actually goes for direct care. This portion of the premium – referred to as the “loss ratio” by insurance companies -- is higher on the medical side but, after the doctors’ administrative costs are deducted from the equation, the true portion that goes to direct patient care is unlikely to reach 70 percent in most plans. It should be noted that a major portion of a doctor’s administrative cost is a direct result of paper work and coordination demanded by the HMOs. Moreover, recent experience shows that when the HMO administrative costs soar, they simply negotiate higher rates with their customers – more than 20 percent over the past two years. When employers balk, the HMOs become more restrictive in allocating care, and try to pass the burden onto providers through capitated “Case Rate” systems or reduced fee schedules. When employers hold the line, the HMO may leave an entire region and go on to greener pastures elsewhere.

So, who’s really at risk? It’s the employers who pay the premiums, the employees and their families who get abbreviated care, and the providers who are cast on the horns of an ethical dilemma – to provide incomplete or inappropriate care and assume greater liability, or to provide proper care and eat the losses. Since managed care companies are not in primary prevention, it’s all about money: reducing and if possible eliminating financial risk – their risk, not that of the patients needing care or the employers who pay for it. If someone actually recovers from their illness, that’s O.K. too, but that is not the primary concern of those who control the financing of health care in this country.

- ***HISTORY***

We have a business model of health care delivery and its primary objective is to make money. With most goods and services the competitive forces of the market place insure good quality at a fair price. In health care, however, competition is waning with the giant mergers and, even when competition is present, consumers are held captive to economic forces that often dictate cost cutting efforts by their employers who buy the health care plans. Experience is showing that it is highly doubtful that the business model of health care delivery and financing, will ever do a consistently good job of serving the needs of those with health problems. Moreover, it is doubtful they will ever fulfill their primary purpose which is to reduce health care costs.

Warren Benis, the famous leadership guru once said, “Content without context is pretext”. So, in order to understand health care delivery and financing in the United States and develop solid concepts for going forward to a better system, it is necessary to look at the history from which the current situation evolved. This evolution defines the context within which we are trying to survive as consumers, practitioners, policy makers and advocates for effective health care, particularly in the badly beaten-up mental health area.

- **In the 1930s and 40s hospitalization insurance came into existence to solve the collection and credit problems of doctors and hospitals** – they needed a mechanism to assure their economic survival, which in turn could give the sick and the injured some assurance of getting treatment.
- **Life insurance companies were already well established** with various types of whole life and annuity plans and had huge assets. (Lower cost term insurance came later.)
- **Agents selling individual and group life insurance learned from their customers that there was a market for hospitalization insurance**. Traditionally, most people have been more concerned with the immediate financial problems of getting sick than with the future problem of death.
- **Life insurance companies saw an opportunity to gain greater access to the huge group life insurance and pension markets by offering hospitalization insurance**. They began to bundle the products and offered employee group indemnity hospitalization insurance on the condition that companies also had to buy group life insurance.

Life insurance premiums, for the most part, were, and still are, fixed during the life of the policy. Thus, in order to survive and, better yet, to thrive, life insurance companies must depend on two factors: (1) the law of large numbers, and (2) a favorable mortality experience. Spreading the risk over large groups of insureds and beating the mortality tables are essential to the viability of any life insurance company. For example, if on average 1,000,000 American males age 30 have a life expectancy of 42 years (age 72), and the actuaries construct the premium rates so all expenses including the death benefit are covered by premiums and accrued interest collected over a 40 year span, the remaining two years of premium yield a profit of approximately five percent. However, if that life expectancy can be lengthened by three years to age 75, profits can more than double. If each of those young men had a $20,000 whole life policy, the life insurance company would have taken in about $12 billion and made $600 million if average age at death was 72. At age 75 the profits would have risen to $1.5 billion -- two and one half times greater. **The objective of a successful insurance company is not to assume risk, but to reduce it and, if possible, eliminate it. Health insurance provided life insurance companies with a great opportunity in this area.**

- ***THE BASIC OPERATING PRINCIPLE***

If a life insurance company had control of the health insurance of its life insurance enrollees, over time it could influence their life expectancy by making sure that the heroic measures that keep people alive longer were covered by the health plan. Until fairly recently, a preponderance of employees were covered by indemnity health plans that were experience rated. In other words, the actual claims experience and administrative costs determined what the premium would be. This enabled insurance companies to retroactively recoup losses if the claims were higher than anticipated. Thus, the life insurance company that controlled the health insurance of its enrollees could pass on the added cost of increased morbidity, while favorably affecting mortality, and reap the gains on the life side of their business. The hospitals and doctors, of course, did not object. They were generally free to treat as they saw fit within the schedule of "usual and customary" fees. The insurance company did not have to make money on the health side -- although they often did – as long as they protected their core business – which was life insurance. While health care costs escalated at 2 to 4 times the rate of inflation in the 1980s, mortality rates went down and life insurance profits rose.

This is not to say that the carriers left themselves totally vulnerable on the health care side of the house. **Often, the administrative costs and profits on health insurance policies were pegged as a percentage of the claims. If health insurance claims increased, so did their administrative fees and profits.** It was the old cost-plus-a-percentage-of-cost contracting that the federal government stopped engaging in after World War II.

With such escalating costs, employers naturally became concerned. For one thing, they were competing in world markets against foreign companies whose governments provided health care to its citizens. Foreign competition didn't have to absorb large health care costs as part of the expense of producing goods and services and this created pressure on American manufacturers to reduce costs. Some of the fallout entailed lowering wages, reducing the size of the workforce and outsourcing work to foreign and non-union suppliers. The desire to contain health care costs intensified. The conditions demanded a new paradigm. The HMOs, which had been around since the early 1970s, stepped up to fill that role.

- ***INDEMNITY DELIVERY REQUIREMENTS***

The indemnity plans paid only for covered illnesses, treated by medical doctors, primarily in hospital settings. Excluded were:

1. Mental health and chemical dependency as covered illnesses;
2. Psychologists, social workers, Certified Addictions Counselors as treatment providers;
3. Outpatient treatment, one to one counseling, group therapy, partial hospitalization, as treatment modalities and settings.

Naturally the cost of care was higher than necessary. The insurance companies were unconcerned because they simply passed the costs on in the form of higher premiums. Since their administrative costs and profits were generally negotiated as a percentage of claims paid, they benefited from cost escalation: the higher the claims, the greater the administrative fees and profits.

Many professionals who were uniquely qualified to help patients were excluded, thus patients did not receive care for their mental and substance use disorders, therefore, the overall recovery rates for the medical problems they presented were adversely affected. But, this made little difference to the insurance companies, the doctors and the hospitals because every got paid regardless of outcomes. Moreover, doing scientific outcome evaluations to determine effectiveness were not seriously considered and still aren't today.

The escalating costs of this system opened the doors for the HMO concept.

- ***HMOs: THE PROBLEM THAT LOOKED LIKE A SOLUTION***

HMOs had great appeal when introduced in the 1970's and '80's, especially to young people, who had few medical problems and had not established a relationship with a doctor. Expanded cover-age for items such as eyeglasses and medications and the absence of co-pays and deductibles were attractive. HMOs also appealed to benefit managers. The prepaid premiums were fixed and could be budgeted over a three-year period much easier than the annual experience rated indemnity plans whose costs kept rising. Further, the objective of keeping people out of hospitals through outpatient care made sense to everyone. To employers the biggest advantage of HMOs was the negotiated provider billing discounts which typically ranged from 25 to 55 percent, varying by facility and level of care.

Few realized that the HMO's actually made matters worse. They created an anti-selection process in which they skimmed off the younger, healthier, less costly enrollees, charged dearly for them, and left the more expensive, sicker, chronically ill enrollees in the indemnity plans. Also, they either disallowed or, at best, provided minimal care for mental and substance use disorders. Studies show that denying or delaying adequate care for such problems has a significant adverse affect on medical costs. When those needing such care were denied access or adequate levels or lengths of treatment, they switched back to indemnity plans to receive the care they needed.

Although they were slow to realize it, to employers this scenario represented the worst of both worlds: the HMO got the prepaid premium and the indemnity plan got the claim for care. In the process, the patient's condition usually worsened, and became more difficult and expensive to treat when they finally did get the care they needed.

- ***ANTI-SELECTION***

Anti-selection was relatively easy to pull off. In the 1980s the HMOs set up tables outside of company lunch rooms. Young, healthy looking employees were the primary targets. Age alone meant they were less likely to have serious health problems and therefore less likely to have an established relationship with a doctor. It also meant they were much less expensive as an insurance risk. Moreover, those with serious health problems, regardless of age, were unlikely to change insurance plans, especially if it meant changing doctors. Then, as now, a relatively small number of enrollees accounted for a large portion of overall costs. And this high risk group – the PARETO GROUP-- were frequently fraught with chronic medical, mental and substance use disorders. Claims analyses we have conducted bear this out:

In 1999 the distribution of health care costs of employers we have worked with have been as follows:

Average annual cost per employee ……………..…….……… $4000
15% represent 75% to 80% of cost and average ….……….. $21,000
85% represent 20 to 25% of cost and average less than ….. $1000.

In the early 1980's these costs were considerably less:

Average annual cost ……………….…………………………..… $1500
15% averaged ………………….……………….……....…. $7500
85% averaged ……………………….…………………….….… $440

Against indemnity plan costs at this level, the HMOs were able to offer services for only $1200 per employee. This was music to the ear of benefit managers. But the HMO's were skimming off an inordinate number of $440 enrollees. Naturally the average cost of those left in the indemnity plan increased. So the following year, the HMOs looked like heroes – they kept their rates firm, while the indemnity plan had to increase their premiums.

The big life/health companies did not take this lying down. As the HMO's penetrated a greater portion of the market, the big traditional insurance companies acquired those that were successful. As a result, the traditional companies ended up "owning" the enrollees whose health care costs average $400 but for whom the $1200 premiums were being paid to the HMOs. Those HMOs that were not successful, ended up with an inordinate number of high cost cases and went out of business.

Now, the other shoe has now fallen. In order to increase market share, HMOs kept prices fairly level for most of this decade. But, they can no longer anti-select on the scale of years past and still increase market share because there is a limited supply of younger, healthier people. HMOs now

have to cover increasing numbers of older and more chronically ill people. Moreover, the morbidity build-up of the chronically ill, the untreated chemically dependent and mental health cases is forcing significant price increases and triggering even more stringent medical necessity criteria. To contain costs, denial of care is rampant. This could require more case management resulting in less money spent on direct care as premiums rise.

Many HMO's have implemented co-pays and deductibles. Moreover, their reserve formulas to cover long tail claims have typically been conservative which, while protecting shareholders, can reduce further the percentage of premium that is actually spent on direct care of enrollee. Further, when HMOs lose customers due to enrollee disenchantment or low ball pricing tactics of competitors, their marketing costs can rise and these are ultimately passed on to their customers, further eroding the amount of money available for direct care.

- ***MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT: HEALTH CARE'S UNWANTED STEP CHILDREN***

After decades of neglect and stigma, mental health and substance use disorders began to gain wide spread recognition as diseases in the 1970s. In the late 1970s and early 1980s treatment of these illnesses began to make headway with insurers, prompted largely by the widespread development of Employee Assistance Programs (EAP) by private and public sector employers and legislation in States such as Maryland and Minnesota which mandated insurance coverage.

The adverse co-morbid impact that unaddressed mental health and substance use disorders wreak on the overall medical costs had been indicated in the literature several years earlier and has continued to this day. More recently, medical claims audits by private consultants indicate that 35 percent to 50 percent of medical surgical expense is related to mental health and substance use disorders that have not been properly addressed. At the same time, there are literally hundreds of outcome studies pointing to the effectiveness of specialized mental health and chemical dependency treatment. Employers that had EAPs were particularly interested in treatment outcomes and the effect on their operations. Many developed benefit to cost analyses and outcome studies of their own. The following are examples of their findings:

OUTCOME STUDIES WERE FAVORABLE, BUT LARGELY IGNORED

1. General Motors "... about 60,000 GM employees have taken part in our Employee Assistance Program ... when they were surveyed one year after treatment between 60 and 70 percent of those employees were still abstaining from alcohol and drugs". Roger B. Smith, Chairman, General Motors, Washington, D.C. December 11, 1983.

"... for every $1 spent by General Motors for treatment of employees in the program, more than two dollars were being returned to us within a period of three years." Thomas A. Murphy, former Chairman, General Motors, Detroit, Michigan, October 5, 1979.[1]

2. Kimberly Clark reported 43% reduction in absenteeism and a 70% reduction in accidents among a sample of employees who participated in their Employee Assistance Program.

3. Philips Petroleum reported that its Employee Assistance Program saved more than $8 million per year in fewer accidents, less sick leave and higher productivity.[2]

4. Kelsey Hayes Center for Counseling and Guidance tracked 58 plant workers involved in the EAP and documented a one year recovery of 18,325 hours, an average of 316 hours per employee.[3]

5. "AT & T Looks at Program Evaluation", Gaeta. E., Lynn, R. and Grey, L. EAP Digest Annual, 1981-82. This reports that in the job performance area 76% of a sample of employees were rated poor at the time of referral to the EAP; 17% fair; 7% good and 0% excellent. Post program results showed 12% poor; 9% fair; 43% good and 36% excellent. The same study showed a decrease in days absent from 421 to 92; a decrease in absence due to disability from 1531 days to 192; a decrease in visits to the medical department from 818 to 439; on the job accidents from 26 to 5 and off-the-job accidents decreased from 26 to 11.[4]

6. At United Airlines a Benefit to Cost Ratio based only on reduction in sick leave use while including all applicable EAP costs was $7 to $1 projected over five years and $17 to $1 projected over the expected career span of EAP participants.[5]

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[1] WORKSITE HEALTH PROMOTION AND HUMAN RESOURCES: A Hard Look at the Data, co-sponsored by General Motors Corporation, U.S. Department of Health and Human Services and the Metropolitan Life Insurance Company.

[2] Ibid.

[3] Ibid.

[4] AT&T LOOKS AT PROGRAM EVALUATION, by Eugene Gaeta, Robert Lynn and Lucille Grey, EAP Digest Annual, 1981-1982

5 The Conference Board, "Substance Abuse in the Workplace", 1985.

BENEFIT TO COST ANALYSIS (BCR)

Several organizations have contracted with an outside consultant to estimate the benefit to cost ratio of their EAP. An important factor in developing such ratios is the cost and effectiveness of mental health and chemical dependency treatment. If such treatment is overpriced or ineffective, the BCR will be adversely affected. Other factors in the formula include the cost of the EAP's operation, cost of sick leave pre/post program use.

The following table summarizes studies that have been conducted over the past 10 years by J. Wrich & Associates, Inc. and include some of the largest and most prominent employers in both the public and private sectors, including both unionized and non-union work environments.

EMPLOYER		PAYBACK PERIOD	BENEFIT TO COST RATIO			OVERALL RATING	
Code	Employees	Months	1st Year	5th Year	10th Year	Score*	Rank
A	900,000	10	1.3 to 1.0	7.2 to 1.0	13.7 to 1.0	12.5	1
B	60,000	14	.8 to 1.0	7.0 to 1.0	15.0 to 1.0	14.5	2.5
C	49,000	18	.4 to 1.0	8.5 to 1.0	15.0 to 1.0	14.5	2.5
D	14,000	23	(2.1) to 1.0	6.8 to 1.0	15.8 to 1.0	17.0	4
E	45,000	11	1.1 to 1.0	6.4 to 1.0	12.3 to 1.0	19.5	5
F	30,000	30	(2.1) to 1.0	5.6 to 1.0	15.3 to 1.0	24.0	6
G	4,500	28	(2.4) to 1.0	6.4 to 1.0	15.2 to 1.0	24.5	7
H	4,800	33	(2.1) to 1.0	4.9 to 1.0	13.6 to 1.0	32.0	9
I	2,500	27	(2.7) to 1.0	5.4 to 1.0	13.8 to 1.0	32.0	9
J	26,000	41	(5.3) to 1.0	5.2 to 1.0	16.7 to 1.0	32.0	9
K	4,200	38	(2.5) to 1.0	3.3 to 1.0	9.0 to 1.0	41.0	11

* Scores are an accumulation of rankings in four categories: Payback Period; 1st year BCR; 5th year BCR; and 10th year BCR. Example: Employer B ranked 4th in Payback Period, 4th in 1st year BCR, 1st in 5th year BCR and tied for 5th in 10th year BCR for a cumulative score of 14.5.

Such results would not have been possible had the type, level and duration of mental health and chemical dependency treatment not been appropriate. Yet, mainstream medical practice and insurance plans, except for a brief period in the 1980s, have not effectively dealt with these issues.

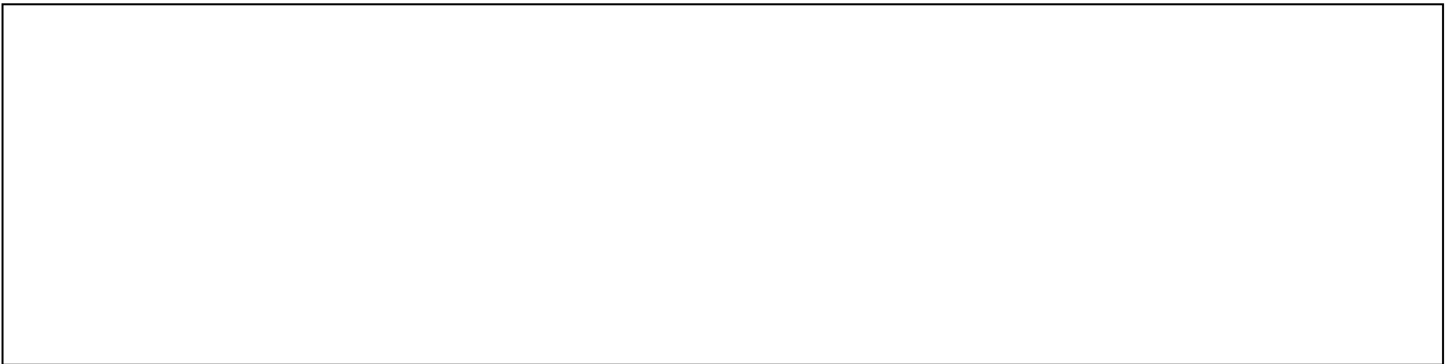
During the 1980s, as the practical advantages of mental health and substance abuse treatment began to be recognized, the demand grew. Since these issues had not previously been covered by insurance, naturally the claims experience began to grow as well. As a percentage of the meager amounts that had previously been expended on mental health and chemical dependency, the trend line increases appeared to be dramatic. But in absolute dollars, these increases and the percentage they represented of total health care expenditures were modest. By the end of the 1980s, insurance plans that covered mental health and substance use disorders were expending approximately 8 percent to 10 percent in this area and studies that indicated that these expenditures had a favorable impact on overall health care costs. Unfortunately, the positive cost impact of mental health and substance abuse treatment was buried in the large increases in medical costs generated by HMO anti-selection processes and other factors, including more sophisticated treatment methods, expensive equipment, an aging population and malpractice litigation.

At the same time, It should also be noted that mental health and substance use treatment providers were not totally blameless. While small in number, some were drastically overcharging and keeping some patients far longer than was medically necessary. This was particularly true of inpatient hospital based adolescent psychiatric and chemical dependency programs. Non-hospital based primary residential programs, such as Hazelden and Betty Ford, were less than half the cost and frequently provided superior care. Moreover, they shared their expertise with health care organizations desiring to start up their own programs. Ironically, they often had difficulty securing insurance reimbursement because the health care industry, dominated by medical doctors, hospitals and insurance companies, regarded treatment that could be delivered largely by non-medical professionals in non-hospital settings as a threat to their economic interests. Lower cost outpatient care was also excluded from coverage except in states such as Minnesota where a legislative mandate was passed over the objections of the insurance carriers and hospitals. Since the insurance companies, as noted earlier, had an economic incentive not to reduce costs, the most cost effective care was frequently not covered. All of this set the stage for the development of what has become known as the managed behavioral health care industry.

Managed behavioral Health Care companies were able to make two compelling arguments to employers as they marketed their services. First, that there was gouging by providers, and a cursory audit of the employers claims could nearly always produce a few high outlier claims which the MBHO firm could declare to have been unnecessary (without studying the facts of the case). Second, they avowed that mental health care was essential and millions in need were getting no care at all, but it had to be managed to assure that the early trend line did not continue its course or parallel what was happening on the medical side of the employees' benefits program.

During the sales process behavioral health care providers were generally cast in an unfavorable light. They were often portrayed as greedy opportunists who would over-treat whenever they had the chance and therefore could not be trusted to look after the benefit manager's concern for controlling costs. While not totally without merit, it did cast aspersions on mental health providers generally, while the abuses were concentrated among a small percentage. Unfortunately, what has followed under the guise of managing care is an array of systematic abuses that are very wide-spread and adversely affect millions of people needing care, thousands of employers who pay for it, and the overall cost of health care in this country.

Without defending the old system, when a few patients were given more care than necessary, the problem was essentially one of financial waste. But, when the sickest of patients, whose conditions have ramifications far beyond the immediate issue of behavioral health costs, systematically receive inadequate care, the result not only increases costs of care but it also increases human suffering and liability exposure. In essence, inadequate care, while cheaper at the moment, is much more expensive in the near future and can put people's lives at risk.



III. How Managed Behavioral Health Care Operates.

"Intention organizes everything" Deepak Chopra.

Audits – Behavioral health ("The content.")

- **Methodology**
- **Scope**
- **Findings**

Audits – Medical HMOs ("The context.")

- **Methodology**
- **Scope**
- **Findings**

Mergers and Acquisitions

- **Debt**
- **Debt Service**
- **General and Administrative Expense**
- **Direct Care Claims Expense ("The leftovers after everyone else eats their fill.")**

MANAGED BEHAVIORAL HEALTH PERFORMANCE AUDITS

As complaints from employees and practitioners mounted, a number of employers have enlisted outside consultants to conduct performance audits of their managed behavioral health care providers. All employers, including the Federal Government, have compelling reasons for concern with the performance of health care systems. In addition to the hundreds of billions they spend each year on care of their own employees, through taxes and cost shifting they also finance a large portion of the care for added millions of Americans who have no insurance.

The following outlines the findings of audits of MBHOs conducted by J. Wrich & Associates, Inc[1]. , a Chicago based consulting firm with nearly 30 years experience in health systems performance. The audits summarized here were commissioned by employers and are of MBHOs which provide service to more than forty percent of the 160 million Americans enrolled in such plans.

Methodology. The methodology incorporated both direct and indirect research methods to review two major categories of information:

1. The Provider's Documentation. This included policies, procedures, internal reports, customer reports, internal audits and evaluations, monitoring processes, the proposal to the customer from which the contract resulted, and the contract itself. The documentation was reviewed with the provider's staff and others as necessary to determine if variances existed between the written material and actual operation.

2. Patient Files. Generally this part of the audits consisted of random sample retrospective reviews of case managers' patient files. Samples were generally stratified by gender, diagnostic categories, age, geography and work groups. Some were also stratified by race. When a service had been in operation a short time, a multi-stage, dense sampling technique was used so the problems normally associated with implementation during the early stages of a contract could be delineated from the ongoing performance.

In some instances interviews with patients and treatment providers were also conducted.

Scope. The audits generally focus on four major areas:

1. Quality of Care. This involves an in-depth review of diagnoses, referral and treatment. It compares type, level and length of care authorized with patients' needs as indicated in the patients' charts. Actual care delivered is also compared to written clinical policies and protocols.

2. Administration. Management of the service is reviewed, to assess the impact of administrative practice on clinical services. Included is quality assurance, accuracy of reported data, and the MBHO's relationship to an EAP or other health care related entities is also assessed.

3. The Provider Network. The network is reviewed for its appropriateness and completeness including a rationale for assuring that the capabilities of selected providers will match expected high prevalence disorders among enrollees.

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[1] J. Wrich & Associates, Inc. (JWA) is a health systems performance company with twenty-seven years experience in the systems development and evaluation areas of substance abuse, mental health, EAP and managed care. Since 1978 we have performed benefit to cost analyses, performance audits and outcome evaluations of EAP and managed care services on behalf of employers and unions including Amoco, Burlington Northern Railway Company, General Motors, Hughes Aircraft Company, the State of Ohio, the State of Minnesota, the City of Chicago, Bridgestone/Firestone, Levi Strauss, Milwaukee County, United Airlines, the United Auto Workers and AFS/CME. We have assisted health care providers such as the Mayo Clinic, Hazelden and Shawnee Mission Medical Center and numerous others on various programmatic issues. Recognized experts are utilized in each of the specific areas reviewed and their respective findings are integrated into comprehensive audit reports.

4. Costworthiness. The ratio of premiums paid to cost of direct services delivered is a major focus. If applicable, we also attempt to assess the comorbid impact of inappropriate behavioral health care practices on the customer's overall medical surgical costs.

In addition to other audit procedures, JWA may review hundreds of pages of the MBHO's policies and procedures; interview several MBHO key management and clinical staff; analyze hundreds of case managers' patient charts; converse with network treatment providers; review claims paid; observe the managed care contractor's intake and screening process; observe the contractor's provider selection process by setting-up double blind mock interviews.

Findings. A number of the audit findings caused concern. While they should not be generalized to the entire managed care industry, there is significant similarity in placement criteria, practice guidelines, network development procedures and pricing among many of the firms to warrant concern. Therefore, caution is warranted when organizations turn the management of their health care programs over to a managed care organization. The following findings, while not universal, are not uncommon in audits we have performed.

1. Overstated utilization. With few exceptions, there was a tendency among MBHOs to overstate utilization. In some instances multiple patient numbers were assigned. One provider issued a new case number each time it authorized additional care. In other instances, case numbers were assigned on an annual basis, thereby counting enrollees more than once if service was provided in two or more calendar years. Several providers combined re-entries with first time users in their counts leading employers to believe utilization was twice the actual rate. One large MBHO typified this problem. While reporting to the customer that more than 5000 patients had used the program, the audit found the number to be less than 3500, an overstatement variation of 45%.

2. Timeliness of Service. Timeliness of service to generally fell far outside of the providers' own performance parameters. The contractor's typical written standards:

Routine cases shall receive service within:	5 days
Urgent cases shall receive service within:	24 hours
Emergency cases shall receive service within:	2 hours

From these standards a blended average elapsed time can be computed for the entire group of enrollees seeking service when the proportions of emergency, urgent and routine cases are known. Based on a sample of more than 1000 patient files JWA has found the following percentages: emergency -- 5 percent, urgent -- 13 percent and routine cases -- 82 percent.

Blended average standard for elapsed time of ………. 4.32 days

Actual performance in of the audited MBHOs showed that the blended average for all cases reviewed by audit ranged from .... 8.5 to 19.3 days

The variation between the contractors' written standards versus actual elapsed time ranged from 97% to 347%.

3. Network Development. When MBHOs serve employee groups in multiple locations, we have found considerable unevenness in provider network development and accessibility.

While it can be difficult and time consuming, it has been JWA's long held position that all providers should be interviewed face to face before patients are referred to them by the MBHO. More recently, the National Council on Quality Assurance (NCQA) incorporated this as a standard. Simply requesting paper confirmation of credentials and liability insurance is not a sufficient basis for assuring that the provider is competent. There was a wide variation

in this crucial area from one MBHO to another. The smaller local and regional providers generally did a better job than the large national firms. Although one large national MBHO had actually conducted face to face interviews with virtually all of its network providers and facilities, this was extremely rare. Well over half of the MBHOs audited did not conduct an interview at all or in only a spotty fashion, and of those that did, most interviewed the providers over the telephone.

Site visits are also important is assessing the quality of care. It was in this area that showed the widest variation in quality of performance. Two firms actually visited the sites of more than 90 percent of its network providers and had regularly scheduled repeat site visits. However, the majority of MBHOs had never seen the offices or facilities of more than 75 percent of its providers. One with several thousand providers had not site visited any except for those against whom there was a serious complaint about service.

Coverage is also crucial and it was frequently spotty, although from a geographic standpoint it has improved over the past seven years. However, when one considers that the vast majority of providers who become network members had been practicing in nearly every locale prior to the commencement of managed care, question arises as to the validity of MBHOs' claims of having "created" a network. Such claims are particularly specious when there has been little effort to personally interview or site-visit providers.

In the implementation phase of a contract, MBHOs can enjoy substantial margins between premium and expense as they build a network. In the case of one MBHO serving a statewide enrollee group, the contractor's proposal and initial agreement called for a minimum of one chemical dependency and one mental health provider in each county. Two years into the contract there were still major gaps in the provider coverage:

- 15% of counties representing 6% of the state's population had no providers at all
- 32% representing 19% of the population had no substance abuse providers
- 16% representing 7% of the population had no mental health providers
- 25% representing 12% of the population had no adolescent/child providers
- 21% representing 9% of the population had no family counselors

The customer paid the full premium on 100 percent of the plan's enrollees during that time frame even though the MBHO's network was never completely in place to serve all of them.

4. Matching Service to Enrollees' Problems. This is one of the most fundamental requirements in delivering effective health care. Yet, provider networks are rarely developed with adequate consideration of expected incidence of high risk disorders. Two landmark studies of incidence and prevalence -- the Epidemiologic Catchment Area Study (ECA) and, more recently the National Comorbidity Study (NCS) -- indicate that as many as 80 percent of the adult population with a current behavioral health disorder have one of four major diagnosis or some combination thereof: substance use disorders, major depressive episode, anxiety disorder and phobia. Only one small regional firm of the managed care organizations audited in this sample had built their networks on a research based rationale of expected patient need reflecting these high incidence disorders. None of the large MBHOs used such a rationale.

These audits found that some MBHOs allow providers to claim expertise in multiple specialties without actually checking competency. In one network audit involving more than 100 providers, the average number of specialties claimed was fourteen with several claiming more than twenty and none showing fewer than five.

In addition, contractor reports on employing minority providers can be misleading. One ploy included high percentages of Asian and Indian providers many of whom were recent immigrants, anxious to build their practices and willing to work for lower fees, as opposed to established African American providers who would have more closely profiled the culture

and ethnicity of the target population, which was roughly 20% African American versus less than 5% Asian and Indian.

5. Patient Chart Reviews. The contents of MBHO case managers were reviewed to assess both the clinical and administrative handling of cases. Chart audits revealed a surprisingly high percentage of problems in the manner in which cases were handled clinically across the full spectrum of service components normally expected from any organization claiming expertise in behavioral health care. Among the more serious findings were the following:

- Significant problems in the diagnostic and referral area (all patient charts reviewed).. 30% to 58%

- Failure to properly evaluate/diagnose/treat substance abuse/ addiction of cases where a substance use disorder was present in the chart documentation, or where there were strong indications of its presence .... 54.8% to 78.3%

- Failure to properly evaluate/diagnose/treat substance abuse/ addiction of total cases reviewed .... 21.9% to 31.3%

- Failure to properly evaluate/diagnose/treat psychiatric disorders of cases where symptoms were present in the chart documentation or where there were strong indications of the presence of a psychiatric disorder .... 4.3% to 8.6%

- Failure to refer patient to provider with a specialty in the diagnosed disorder for which the patient required treatment .... 4.0% to 13.2%

- Failure to follow-up .... 6.3% to 78.8%

- Failure to follow-up on cases indicating symptoms which put the patient at risk .... 5.4% to 19.1%

- Instances in which patient had not received care within three months of initial contact due to delays in authorization or other administrative/clinical problems .... 4.1% to 26.0%

The frequency of administrative problems which had an impact on delivery of care varied widely among MBHOs. This included delays in answering telephone inquiries; failure to authorize care in a timely manner; problems with payment of claims. Instance where there were significant administrative handling problems .... 6.5% to 26.7%

When charts with clinical problems are combined with those having and administrative handling problems these audits found care to be potentially jeopardized in a very significant number of cases ....37.0% to 86.0%..

6. Patient Placement Criteria. Some of the problems found in the patient chart review resulted directly from the MBHO's practice guidelines, the most significant being in the patient placement criteria. The audits showed that the criteria for inpatient, residential or intensive outpatient treatment is often extremely restrictive. For example, one audit found that the MBHO required **all** of the following for treatment above the individual outpatient level:

- Treatment limited to Axis I, DSM III R diagnosis. Excluded Axis II disorders, including the various personality disorders, obsessive-compulsive disorder, and mental retardation.

- Several types of disorders, including substance abuse/addiction required prerequisite treatment failure at a lower level of care before inpatient or intensive outpatient care, was authorized, and ...

- An attempt to harm self within the previous 24 hours, or significant action or harm to another person within previous 24 hours, or significant threatening action to damage property with high lethality in order to receive inpatient care and, in some instances, intensive outpatient care.

Another audit revealed that the criteria itself for admission to detoxification services put the patient at risk because it required a confirmed diagnosis of addiction plus indication of delirium tremens (DTs). Most experts agree that a major purpose of detoxification services is to prevent DTs. Moreover, intoxication with withdrawal symptoms in itself indicates a need for detoxification services without a time consuming, confirming diagnosis of addiction. Yet another audit found discharge from detoxification was required simply if the patient was no longer dysfunctional due to delusions or hallucinations without regard for other serious symptoms that may have necessitated continued stay.

7. Premium Allocation: Administrative Loadings and Profit versus Direct Care Expenditures (Loss Ratio) In these audits administrative loadings and profit totaling 50 percent or more of the premium paid in “at-risk” carve-outs were commonplace. JWA has stated that to date it has yet not reviewed such an arrangement in which the combination of administra-tive loadings and profit was less than 45 percent of the employer’s premium. Because of this, the State of Maryland passed legislation in 1999 requiring MBHOs to disclose their loss ratios. .

One audit in this report showed that during a two year period the MBHO had a maximum pay-out of 38.5 percent (including the direct service cost of its own staff) for clinical service resulting in estimated administrative and profit loadings of approximately 61.5 percent ($7,000,000 annual premium vs. $2,292,000 year 1 and $2,595,000 year 2 in direct care expenditures.)

In another audit the estimated MBHO’s pay-out for direct care was 49.5% of premium. But during the audit, the MBHO was simultaneously offering the customer a five year cap on the current premium while inducing its network providers to accept a “case rate” or capitated fee system at $275 per case for MSW’s and Ph.D’s and $425 for M.D.s in exchange for a waiver of case management or utilization review. Had all providers accepted this “case rate” system, the MBHO’s direct care pay out could have been reduced to as little as 28 percent of premium. If only half the providers had accepted, the estimated direct care payouts would have amounted to approximately 36 percent of the premium. Both estimates included the actual dollar amount for residential care that was expended under the original contract.

The implications of these findings are very significant. Traditionally, behavioral health care has represented less than 10 percent of total health care costs with the other 90 percent expended on medical surgical disorders in plans that provided mental health coverage. More recently, the estimates range from 3 to 5 percent for behavioral health care. In conducting studies of medical surgical claims, like many other health care consultants, JWA reports that it consistently finds that a PARETO group generally consisting of 15 percent of the enrollees represent approximately 75 to 80 percent of the claims expenditures, with 5 percent consuming 40 percent to 55 percent of the total expenditures. It is estimated that chronic behavioral health problems, largely undiagnosed and untreated, are involved in 70 to 75 percent of these PARETO cases. Even if behavioral health issues were totally absent among the remaining 85 percent of claimants, they would still have a bearing on more than 50 percent of total health costs. In other words, roughly half the money spent

on medical problems is not likely to result in a permanent solution because mental health and substance use disorders are either ignored or improperly treated. Case records indicate that the single most frequent undiagnosed or improperly treated behavioral health problem is substance use disorder followed by anxiety disorders and major depressive episode.

MEDICAL HMO PERFORMANCE AUDIT

SUMMARY of FINDINGS

At the request of the State of Vermont, J. Wrich & Associates, Inc. (JWA) has made a comparative cost analysis of the two HMOs – Kaiser Permanente (KP) and MVP – which serve State employees, and the State's self-funded Choice Plus indemnity plan for 1998. The objective was to find out what the average per employee cost of the Choice Plus plan would be if it was serving HMO-like enrollees, and to compare this estimated cost to that charged by the HMOs.

It is important to note that retiree lives are not included in this study. So few retirees choose HMO coverage that a valid comparison between Choice Plus and HMO's could not be made if retirees were included, even though they are a significant factor in the overall cost of the Choice Plus plan.

The sampling was a critical step in the process. Based on data provided by the State, JWA compiled a profile of HMO enrollees based on age, gender, type of plan and marital status. Controlling for these characteristics, JWA then selected a sample of 597 (20%) Choice Plus claimants who matched the HMO claimants' profile. We also analyzed the cost of prescription drugs for Choice Plus enrollees using the same sampling method. The claimants selected from the Choice Plus data for this comparative analysis were no less than 98.5 percent representative of the HMO enrollee population in terms of age; 99.6 percent in gender; 99.3 percent in type of plan. Experience shows that when comparing enrollees by a combination of age, plan type and gender an accurate overall estimate will result. We believe the estimate of average cost per employee is accurate to within plus or minus 1 percent.

Overall, when controlling for these variables the cost to the State of Vermont averaged $3910 for HMO covered employees versus $3786 per covered employee in the Choice Plus including $326 for administrative costs and $640 for prescription drug charges.

Beyond the average cost per employee is the all important question of amounts spent for direct care in the HMOs versus the Choice Plus plan. Typically, about 80% of HMO premium goes for direct care and 20% for General and Administrative (G&A) and profit. Had that been the case here, the average amount available per employee for direct care would be only $3128 for the HMOs versus $3460 for Choice Plus, a difference of $332 per employee. Thus, while Choice Plus premiums for "like" enrollees would be 3.2% less, the amount spent on direct care would actually be 10.6% more.

In reality, we found that the actual loss ratios for Kaiser and MVP covering their entire books of business in Northeast U.S were much higher than 80% of premium: 93.2% for Kaiser and 88.1% for MVP. This computes to a per employee average of $3367 for direct care. When administration costs are included this business was not profitable and the $3910 premium charged to the State was not sufficient to cover the costs. The two HMOs combined to lose about 5% overall, while in Vermont their losses were 10%. Even so, at an average of $3367 per employee the HMOs' expenditures for direct care were still less than the Choice Plus plan.

In addition, the reserves formula for "long tail" claims can be an issue. To protect shareholders, insurance carriers are typically more conservative than self funded plans when calculating reserves. But if surpluses result, the carriers are not compelled to spend them on direct care even though they were funded out of employer premium payments and employee contributions.

These factors point to significant future HMO premium increases with no assurance that expenditures for care will be comparable to Choice Plus. In summary, it can be concluded that for a "like" population of enrollees the State of Vermont pays more for the HMOs and receives less in dollars expended for direct care. The following pages summarize the process and calculations used to arrive at this conclusion.

METHODOLOGY: MODEL SAMPLE OF HMO CLAIMANTS.

JWA first reviewed the HMO employee claimant population of 2991 employees. A sample of 597 was randomly selected. Figure 1 compares the variables of the total population with the sample.

Figure 1

Group	Total	Male	Female	Single Coverage	Two Person Coverage	Family Coverage
Control	2991 100%	1587 53.1%	1404 46.9%	870 29.1%	740 24.7%	1381 46.2%
Model Sample	597 100%	319 53.4%	278 46.6%	173 29.0%	146 24.5%	276 46.2%
Match: Control vs. Sample	N/M	99.4%	99.4%	99.7%	99.2%	100%

The 1998 data shows that the average age was virtually the same for the controls and the sample: 41.1 years for women and 41.7 for men.

We then turned to the Choice Plus employee group and selected 597 like claimants that matched the HMO Model Sample. Within each of the most critical segments (age, gender, and plan type) a number equivalent to those in the Model Sample were randomly selected. Figure 2 compares critical variables of the Actual Choice Plus Sample to those of the Model and the degree to which they matched.

Figure 2

Group	Total	Male	Female	Single Coverage	Two person Coverage	Family Coverage
Model Sample	597 100%	319 53.4%	278 46.6%	173 29.0%	146 24.5%	276 46.2%
Actual C P Sample	597 100%	320 53.6%	277 46.4%	174 29.1%	145 24.3%	278 46.6%
Match: Model vs. Actual CP	100%	99.7%	99.6%	99.4%	99.3%	99.3%

SCOPE: THE COMPARATIVE COST ESTIMATES: HMO vs. CHOICE PLUS

A. Total Cost per Employee

The State advises that HMO premium averaged $3910 per employee in 1998 across all plans, prescription drug costs and General and Administrative (G and A) expense included. This appears to be far less than Choice Plus costs, which averaged $4656 per covered employee, including $326 for administration and an amortized average of $704 for prescription drugs. **But when comparing "like" claimants the picture changes dramatically.**

Per the State, the average age of active employees in the HMOs is now 42.1 versus 48.2 for Choice Plus. Annual medical claims for the active Choice Plus "HMO-like" Sample averaged $2820 per person. Prescription drug costs amortized over the total claimant population averaged $640. Including $326 for administrative costs, the total comes to $3786. Figure 3 compares the HMOs' costs with (1) the entire Choice Plus active employee population and (2) the Choice Plus Sample of "HMO-like" claimants.

Figure 3

	Amortized Medical Claims	Amortized Drug Claims	Amortized Administrative Expense	Total Estimated Claims/ Premium Cost
*All Choice Plus Plan Active employees	$3626	$704	$326	$4656
All HMO Plans Active employees	Included In total	Included In total	Included In total	$3910
Choice Plus "HMO-Like " Sample	$2820	$640	$326	$3786

*IMPORTANT NOTE. The $4656 does not include retiree claims. This means that overall, the "older" Choice Plus actives are significantly more costly ($4656 vs.$3786) than the Choice Plus "HMO-like" sample.

B. Estimated Expenditures for Direct Care

Neither of the State's HMOs had claims data specific to State of Vermont enrollees. Thus, in order to estimate the amounts spent on direct care, we have developed two scenarios. The first assumes that the HMO premium of $3910 is sufficient to cover all medical claims, General and Administrative expenses plus a profit. To estimate the amount spent on direct care we deducted estimated General and Administrative cost and profit from the $3910 premium. The second scenario is based on Kaiser's and MVP's actual costs for their entire books of business in Northeastern United States.

Scenario 1

1. <u>The HMOs.</u> In the absence of HMOs' loss ratio data specific to the State's employees, we turn to the Literature which reports that HMOs typically have a loss ratio (premium less General and Administrative and profit) of approximately 80 percent. Applied to the HMOs serving State of Vermont employees, G & A plus profit computes to ……… $782

2. <u>Choice Plus Plan.</u> The State of Vermont advised that the average administrative

cost per covered employee for the Choice Plus plan is ………………………………. $326

Figure 4 shows the resulting impact on dollars available for direct care for the two plans.

Figure 4

	Total Cost/Premium per Covered Employee	Administrative and Profit	Net Available for Direct Care
HMOs	**$3910**	**$782 (20.0%)**	**$3128 (80.0%)**
Choice Plus Sample	**$3786**	**$326 (8.6%)**	**$3460 (91.4%)**
Difference CP vs. HMOs + (-)	**($124) (3.2%)**	**($456) (11.4%)**	**$312 10.6%**

Scenario Two

We reviewed the "Five Year Historical Data" reports of MVP and Kaiser which included profit and loss statements for their total books of business in Northeastern United States. As mentioned, these reports did not break out the State of Vermont enrollee data but they do provide insight into where the HMOs' premium rates may be heading. Kaiser's direct care costs averaged 93.2 percent of premium while MVP's averaged 88.1 percent, for a blended pro rata average of 91.4 percent. As a percentage of premium, Kaiser's administration costs were 15.3 percent and MVP's were 11.4 percent, for a blended pro rata average of 13.9 percent. Blended, the HMOs' actual total costs represent 105.3 percent of the premium received for their books of business. MVP had a minimal profit and Kaiser had a significant loss, and when blended, there is a 5 percent loss. As shown in Figure 5, **when deducting the administration and profit from the $3910 premium the State pays for HMO services, the Choice Plus plan, in spite of costing less overall, spends more on direct care for a like population of enrollees.**

Figure 5

	Premium	**Total Cost 1998 (% of premium)**	**Administration (% of premium)**	**Profit (loss)**	**Net Available For Direct Care**
Kaiser	$3910	$4246 (108.5%)	$598 (15.3%)	($336)	$3312
MVP	$3910	$3890 (99.5%)	$446 (11.4%)	$20	$3444
HMO ***Blended***	$3910	$4117 (105.3%)	$543 (13.9%)	($ 207)	$3367
Choice Plus Sample	N/A	$3786	$326 (8.6%)	N/A	$3460

III. THE COMPUTATIONS

The computations were based on data provided by the State. Choice Plus and drug claims data were converted from cost per claimant to an average cost per covered employee because HMO premium costs were based on covered employees, not claimants.

A. HMO Premium

The State advised that the blended average premium for HMOs in 1998 was ……….. **$3910**

B. All Choice Plus Active Employees Cost

1. Medical Claims
$12,060,260 in Medical claims were incurred in 1998 for 3188 employee claimants for an average of $3783 per claimant. Total covered employees were 3326. Thus, the amortized average cost for Choice Plus covered employees is …………………………………………………………………… $3626

2. Prescription Drug Claims
Prescription drug claims for incurred in 1998 for 1638 employee claimants totaled $2,340,604. When amortized over 3326 total covered employees the average cost for prescription drugs is ………….….…. $704

3. Administration Costs
The State of Vermont advised that the average per covered Employee cost of administration for the Choice Plus plan is …………..….…… $326

Total ……………………..… $4656

C. Choice Plus "HMO-like" Sample

1. Medical Claims
Total medical claims for the Choice Plus sample of 597 HMO like claimants was $1,756.476. The employee claimant to covered employee ratio in the Choice Plus Plan is 3188 divided by 3326, or .9585. Thus the formula for amortizing the sample costs is $1,756,476 divided by 597 X .9585, or….… $2820

2. Prescription Drug Claims
We used the same profiling and sampling method for drugs as was used to create the sample for medical costs. Drug claims for a Choice Plus sample of 318 HMO like claimants was $413,108. The drug claimant to medical services claimant ratio for the Choice Plus plan is 1638 to 3188, or .5138. The claimants to covered employees ratio is 3188 to 3326, or .9585. Thus, the formula to amortize drug costs across all Choice Plus covered employees is $413,108 divided by 318 X .5138 X .9585, for a per employee average of ……. $640

3. Administration Costs
The State of Vermont advised that the average per covered employee *cost of administration for the Choice Plus plan is …………………………..…….. $326*

Total ……………………… $ 3786

IV. CONCLUSIONS and SUGGESTIONS

At first blush, the State of Vermont's HMOs appear to be providing service at a much lower cost than the State's self funded Choice Plus plan. At $3910 per employee average versus the $4656 average for Choice Plus the $746 difference appears to be significant. However, the HMO enrollee group is currently six years younger on average: 42.1 to 48.2.

When controlling for age, gender, and type of coverage, the Choice Plus plan is actually less expensive to the State -- $3786 versus $3910. Moreover, when factoring out administrative costs, the Choice Plus plan expends more money for direct care ($3460) than either Kaiser ($3312) or MVP ($3444). If HMO reserve formulas are more conservative than Choice Plus, as is frequently the case when comparing insurance company plans to self funded plans, the HMOs' direct care expenditures could be even lower, increasing the difference in these expenditures when compared to the Choice Plus plan. Interest on reserves and any applicable premium taxes targeted to non-domiciled HMOs could also increase the difference.

The HMO's have total blended costs representing 105.3 percent of the current $3910 premium. This is not surprising because HMOs nationally have been "buying into" the market over the past few years. However, our clients are now reporting HMO premium increases of 11 to 28 percent. With Kaiser pulling out of Vermont, a large portion of its business has ended up with MVP. The medical claims costs of Kaiser's enrollees were 12.4 percent higher than MVPs in 1998. Also, MVP had a much larger liability of unpaid claims. These factors, combined with less competition could cause MVP's premiums to increase even faster than what one might ordinarily expect in the current environment.

In our experience, whenever an employer has both a self-funded plan and an HMO there is anti-selection that usually favors the HMO. This appears strongly to be the case with the State's employee health care plans. The State should seriously consider creating a single risk pool. If possible, and if it would be to the State's advantage, consideration might be given to "renting" the HMOs' administrative services while maintaining a single risk pool.

In a separate study we reported to the State that a small percentage of Choice Plus enrollees account for a significant portion of the claims expense. A PARETO Group of 15% of the 1998 claimants represented approximately 76 percent of the cost. The same ratios apply to HMOs we have reviewed. The State needs a strategy for effectively managing this large liability, which computes to roughly $20 million per year.

Properly managing the PARETO group is the key to containing health care costs. Neither HMOs nor indemnity plans have the mechanisms for doing so. The State needs an integrated system to assure that enrollees get the right care the first time for both medical and behavioral disorders, along with adequate aftercare, follow-up and self care regimens. A strong decision support program to assure healthy life style changes and an information system that tracks both clinical and financial outcomes must buttress this system. A pilot program of this type for a Chicago area employer has yielded significant reductions in overall health care costs by appropriately managing the PARETO group and implementing other plan changes.

MERGERS AND ACQUISITIONS: IMPACT ON CARE

The debt and debt service incurred as a result of mergers and acquisitions can add anywhere from 5 to 35 percent to total costs, without adding value or generating off-setting operational efficiencies. These costs are passed on to the customers. Let's set up a hypothetical but plausible example of a huge managed behavioral health care company that was put together largely through acquisitions involving several large and medium sized MBHO companies.

Assume that the acquisitions cost roughly $1.3 billion and that total combined revenue was $1 billion. Assume that all of the business is at risk – in other words the MBHO company is functioning as an HMO. If the debt service on the acquisition cost is 10%, that means $130 million has to come right off the top of the $1billion in revenue. This leaves $870 million to operate the company. Next, the debt itself has to be paid. On a ten year schedule, this represents another $130 million per year, leaving $740 million. Then, there is the administration and overhead costs, usually about 25% or $250 million per year. Now we are down to $490 million out of the $1 billion in premium revenue. But it doesn't end here. In order to be viable on Wall Street, there has to be a profit. So if a 12% pre-tax profit is projected, another $120 million must be deducted. This leaves $370 million available for direct care out of the $1 billion in premiums paid by employers. Thirty-seven cents on the dollar. Of the audits we have conducted of "at risk" managed behavioral care services, no more than 55 cents per premium dollar has gone to direct care and, in some cases it was as little as 37 cents.

Total Revenue (Premium)	**$1,000,000,000**
Major Expense Categories	
• Debt Service	$130,000,000
• Debt reduction	130,000,000
• General and Administrative Expense (25%)	250,000,000
Sub-Total Expenses	**$510,000,000**
• Profit (12% pretax)	120,000,000
Total Expenses and Profit	**$630,000,000**
Net Available for Direct Care	**$370,000,000**

Of audits we have conducted of "at risk" managed behavioral care services , no more than 55 cents per premium dollar has gone to direct care, and in some cases, as little as 37 cents.

In 1990 behavioral health care represented about 8% to 10% of overall healthcare costs in plans covering mental health and substance use disorders compared to the current estimated level of about 3.5% to 5.0%. But as the scenario above shows, a major portion of that 3.5% to 5.0% is not going for direct care. The affect on care has been so devastating that none of the managed care companies with which we are familiar even bother to conduct valid clinical outcome studies.

IV. How Managed Behavioral Health Care Impacts Providers, Patients and Payors.

"The Upstream benefits of downstream risk transfer." Jim Wrich

Providers

- **Downstream Risk Transfer**

Patients

- **Long Odds of Getting the Right Care**

Payors

- **Comorbidity**
- **Lack of Accountability**

IMPACT ON PROVIDERS

DOWNSTREAM RISK TRANSFER

Managed behavioral health care (MBHO) firms have significantly reduced mental health and substance abuse treatment expenditures in recent years. Most of this reduction has come as a result of denial of care. But, with the near elimination of service at the inpatient, primary residential, intensive outpatient and partial hospitalization levels, MBHOs have nowhere else to reduce fees except at the individual and group therapy levels. Having reduced the number of therapy sessions at this level, they are running out of room in which to cut costs further without virtually eliminating care altogether. The only place left to go is to reduce practitioner fees. Our analyses in the behavioral health area show that such schemes will devastate private practitioners economically, forcing them to work longer hours for considerably less money. In the meantime, the MBHOs will prosper immensely. Both scenarios are outlined in the following tables.

- ***AFFECT ON PROVIDERS'FINANCIALSECURITY***

WHEN HOURLY FEES ARE	**$80**	**$70**	**$60**	**$55**	**$50**
and, **Weeks worked per year are …**	**47**	**48**	**48**	**48**	**49**
and, **Billable hours per week are …**	**25**	**28**	**30**	**32**	**32**
Therapist total work hours per week are likely to be …	**40**	**45**	**48**	**53**	**53**
Gross Annual Revenue Will Be ...	***$94,000***	***$94,080***	***$86,400***	***$84,480***	***$78,400***
When expenses* are ...					
Rent	$9000	$9000	$9000	$9000	$9000
Prof. Liability Insurance	1000	1000	1000	1000	1000
Telephone	1000	1000	1000	1000	1000
Furniture/Equipment	2000	2000	2000	2000	2000
Supplies	1000	1000	1000	1000	1000
Part Time Admin. Assistant	12,000	12,000	14,000	15,000	15,000
Health Insurance	5000	5000	5000	5000	5000
Sub-total Expenses	**- $31,000**	**- $31,000**	**- $33,000**	**- $34,000**	**- $34,000**
Net Income Before FICA Will Be …	***$63,000***	***$63,080***	***$53,400***	***$50,480***	***$44,400***
FICA**	- 9500	- 9500	- 8000	- 7600	- 6700
RESULT: TAXABLE ANNUAL INCOME OF …	***$53,500***	***$53,580***	***$45,400***	***$42,880***	***$37,700***

* These are estimates only. Actual expenses will vary by practitioner and geographic area.

** Includes both employer's and employee's contribution.

- ***THE UPSTREAM BENEFITS.***

Not everyone loses when the risk is transferred downstream. The following calculates the potential increase in profits when a managed behavioral health care company reduces its fees to private psychotherapists from $70 per hour to $55. This hypothesis is based on the bottom line impact such a fee reduction could have on a moderate size MBHO.

	When fees are $70 per hour	**When fees are $55 per hour**	**% Change + (-)**
MBHO Annual Revenue	$200,000,000	$200,000,000	N/C
Direct Care Expense	120,000,000	94,300,000	(21.4)
Gen. & Admin	50,000,000	50,000,000	N/C
Pre-tax profit	30,000,000	55,700,000	85.7
Taxes (35%)	10,500,000	19,500,000	85.7
Net Profit	**$ 19,500,000**	**$ 36,200,000**	**85.7**

Operating profit is only part of the story. An additional consideration is the potential increased value of a company in the event of a merger or acquisition. A company's value is largely influenced by cash flow, a major element of which is profit. If the MBHO in this scenario was sold or merged, the "Downstream Risk Transfer" strategy outlined here could increase its value by $100 million or more, which would be reaped by the owners.

IMPACT ON PATIENTS

- ***LONG ODDS OF ADDICTED PEOPLE GETTING THE RIGHT CARE***

That there were abuses by health care providers prior to managed care is undeniable. That they were of the epidemic proportion claimed by the managed care companies is a gross overstatement. That managed care, has reduced costs is questionable – in fact there is growing evidence that it increases the cost of health care overall. The notion that managed care practices have improved care, is a falsehood, particularly in the behavioral health arena. One need look no farther than the one of the biggest health care and social problems of the past twenty five years – substance use disorders. Based on the performance audits above, the odds averages of someone getting the right care the first time in these programs are outlined in the following table.

ODDS OF CHEMICALLY DEPENDENT PEOPLE GETTING THE CARE THEY NEED IN A TYPICAL MANAGED CARE ARRANGEMENT[2]

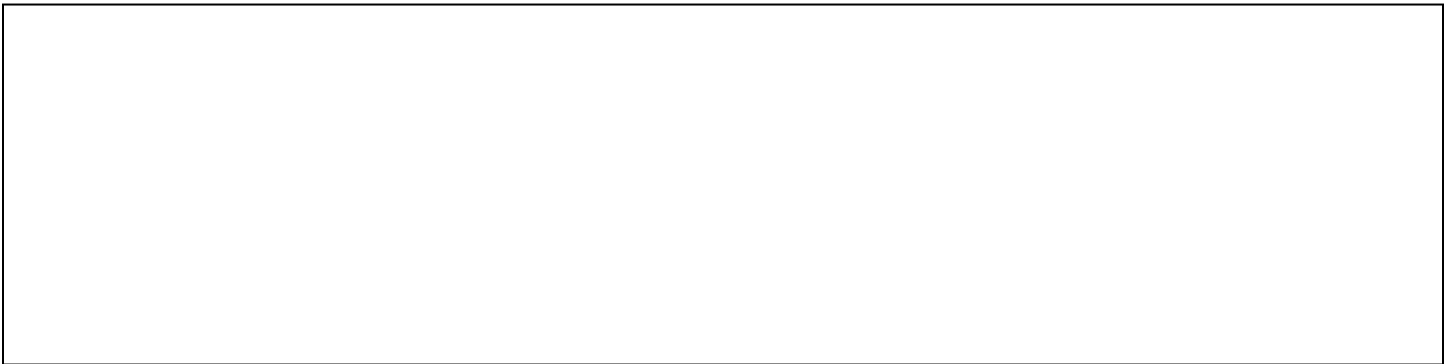
1000 CASESBARRIER	BEST CASE SCENARIO	WORST CASE SCENARIO
• Failure to Diagnose when strong Indicators are present In the MBHO's case managers' charts.	54.8%	78.3%
Remaining Cases	452	217
• Failure to refer to providers with a specialty in addictions	4.0%	13.2%
Remaining cases	434	188
• Patient had not received care within three months due to administrative problems	4.1%	26.0%
Remaining cases	416	139
• Level of care insufficient per ASAM Criteria	41.0%	72.0%
Remaining cases	245	39
• Length of stay insufficient per ASAM criteria	37.5%	61.4%
♦ **Remaining Cases:** Those likely to have received appropriate care for their addictions the first time contacting their MBHO	**153**	**15**

* Does not include cases in which symptoms were not properly recorded in the case manager's charts. Includes cases meeting John's Hopkins or SASSI criteria.

It is not a coincidence that the number of beds to treat chemically dependent people has shrunk from roughly 50,000 in 1989 to fewer than 8000 at present. While the Federal government spends billions to attack the supply side of the drug issue in this country, the demand side of the problem is being largely neglected by MBHOs. While less dramatic, similar scenarios can be developed for

[2] Source: J. Wrich & Associates, Inc., Chicago, Illinois. Based on chart reviews of performance audits of managed behavioral care organizations (MBHOs) that represent approximately 40 percent of the lives covered by MBHOs in the United States.

anxiety disorders and major depressive episode, which, with substance use disorders constitute approximately 75 percent of those with a current mental health problem of sufficient seriousness to be listed in the Diagnostic Statistical Manual of Mental Disorders (DSM IV).



IMPACT ON PAYORS

ESTIMATED COST OF COMORBIDITY
JWA Aggregate Claims Sample
SUMMARY

TOTAL MEDICAL CLAIMS …………………….. $126,529,548

- **Minimum impact $43,994,513**
- **Likely impact $63,288,734**

ESTIMATED COMORBIDITY RANGE ……….. 34.8% TO 50%

PAYORS

ESTIMATED COST OF COMORBIDITY
JWA Aggregate Claims Sample
Detailed Analysis by ICD-9 Category

ICD-9 Category	ICD-9 Code	$$ Paid	% of Total $$ Paid	Comment*	% Est. Comorbidity MH/CD**	$$ at Risk Due to C/M (Low)	$$ at Risk Due to C/M (High)
Diseases of the Circulatory System	390-459	$15,734,316	13	Alcoholics have 1.6 to 1.9 times the rate of the gen. pop.	32-49	$5,041,381	$7,719,615
Diseases of the Digestive System	520-579	10,873,280	8	Alcoholics have 2.4 times the rate of the gen. pop.	43-65	4,675,510	7,067,362
Diseases of the Genitourinary System	580-629	10,075,692	8	Not significant	N/S	N/S	N/S
Neoplasms	140-239	14,167,826	13	Alcoholics have 2.1 times the rate of the gen. pop.	38-56	5,383,774	7,933,983
Diseases of the Musculoskeletal System and Connective Tissue	710-739	11,979,378	10	Alcoholics have 2.7 times the rate of the gen. pop.	49-73	5,869,895	8,804,843
Complications of Pregnancy, Childbirth and the Puerperium	630-679	4,017,272	3	Alcoholics have 1.6 to 1.9 times the rate of the gen. pop.	32-49	1,285,527	1,968,463
Mental Disorders	290-319	5,496,206	5	Alcoholism has very high co-morbidity rates with all high incidence mental disorders, i.e.: Affective Disorders, Anxiety and V-Codes	100	5,496,206	5,496,206
Infections	001-139	1,986,730	2	Most infections do not have a high C/M rate with MH/CD. However, sexually transmitted diseases do: alcoholics have 1.8 times the gen. pop. rate	33-50	655,621	993,365
Endocrine, Nutritional and Metabolic Disease, Immunity Disorders	240-279	3,782,640	4	Alcoholics have 2.7 times the rate of the gen. pop.	49-73	1,853,494	2,,780,240
Diseases of the Blood and Blood Forming Organs	280-289	972,836	1	We do not have C/M estimates for this disease category.	Unknown		
Diseases of the nervous System and Sense Organs	320-389	5,171,154	5	Alcoholics have 1.5 times the rate of the gen. pop.	27-41	1,396,212	2,094,317

ESTIMATED COST OF COMORBIDITY
JWA AGGREGATE CLAIMS SAMPLE, continued …

Diseases of the Respiratory System	450-519	$8,942,748	7	Alcoholics have 1.5 to 2.5 times the rate of the gen. pop.	36-54	$3,219,389	$4,829,084
Diseases of the Skin and Subcutaneous Tissue	680-709	1,918,764	2	We do not have C/M estimates for this disease category.	Unknown		
Congenital Anomalies	740-759	1,120,688	1	We do not have C/M estimates for this disease category.	Unknown		
Certain Conditions originating in the Perinatal Period	760-779	5,764,668	3	We do not have C/M estimates for this disease category.	Unknown		
Symptoms, Signs and Ill-defined Conditions	780-799	11,889,054	9	Alcoholics have 1.8 times the rate of the gen. pop.	32-49	3,804,497	5,706,746
Injury and Poisonings	800-999	9,398,226	8	Alcoholics have 2.7 to 3.5 times the rate of the gen. pop.	56-84	5,263,007	7,894,570
F.I. Health Status	N/A		3	N/A			
TOTAL		**$126,529,548**				**$43,994,513**	**$63,288,734**

* Source: Various national research studies.
** The incidence of mental health problems is approximately 50% greater than substance use disorders. Thus, the low end of the range is based on substance use disorders (primarily alcoholism) and the high end is based on mental disorders.

WHAT HAS MANAGED CARE COST YOU, THE INDIVIDUAL PRACTITIONER?

CONTEXT

- In 1985 the typical hourly fee for LCSW …………………………………….. $60 US
- Using the Consumer Price index in 2005 the comparable fee is ………. $106 US

DEVIATION FROM THE CPI

- When MBHO fees deviate $20 from the CPI comparable fee, over ten years the typical practitioner who provides 1200 billable hours of care annually, will lose ……………………………………………… $240,000 US gross

- When MBHO fees deviate $30, the ten year loss is ………………..... $360,000 US gross

- When MBHO fees deviate $40, the ten year loss is ……………… $480,000 US gross

IMPACT

On a practical level, had your fees kept pace with inflation….

- Would you still have a mortgage on your home?

- Would educating your children been such a challenge?

- Would you worry as much about your retirement?

- ***LACK OF ACCOUNTABILITY***

Managed care has not been subjected to performance tests which objectively evaluate what difference their decisions make in the lives of patients.

Do patients get better, stay the same or get worse as a result of managed care practices?

It's a question the MBHOs have not had to answer. Generally, they have simply been allowed to squeeze the dollars while bearing no responsibility for clinical outcomes. If failure to treat substance use disorders leads to gastrointestinal problems, or an automobile accident requiring emergency room care, there are virtually no consequences to the MBHO unless the aggrieved party or their family sues. Then, the managed care company has been protected by ERISA. If failure to properly treat depression or anxiety leads to an attempted suicide because the patient needed care at a more intense level than outpatient, typically the patient is blamed: "… patient is not responding to care", and "… patient is not complying …" are comments we often found in MBHO case managers' patients' records. In one case, where the treating psychiatrist was begging the MBHO to allow him to admit a 14 year old girl for observation in a psychiatric hospital because of suicidal ideation, the case manager's note in the chart read, "… [patient] not suicidal enough."

But, a watershed may finally have been reached.

- ***CURRENT DIRECTIONS***

The Context.
In order to increase market share, HMOs kept prices fairly level for most of the 1990s. But they can no longer anti-select on the scale of years past and still increase market share because there is a limited supply of younger, healthier people. HMOs now must cover increasing numbers of older and more chronically ill people. Moreover, the morbidity build-up of the chronically ill, the chemically dependent and mental health cases is forcing significant price increases and triggering even more stringent medical necessity criteria.

The Content.
Since nearly all the major medical HMOs subcontract the mental health benefit to an MBHO, the kind of care for mental and substance use disorders that could reduce the need for ongoing comorbid medical care is not being delivered. Hence their medical claims will continue to rise. To contain costs, denial of care is likely to increase which could require more case management resulting in an even smaller potion of the premium dollar being spent on direct care. This, of course will lead to even greater consumer dissatisfaction.

To offset these factors, some HMOs are attempting "down stream risk transfer" ploys outlined above, which reduce fees to direct care providers through "case rate" and capitated fee schedules.

But ….

…change is possible if those capable of triggering it take action.

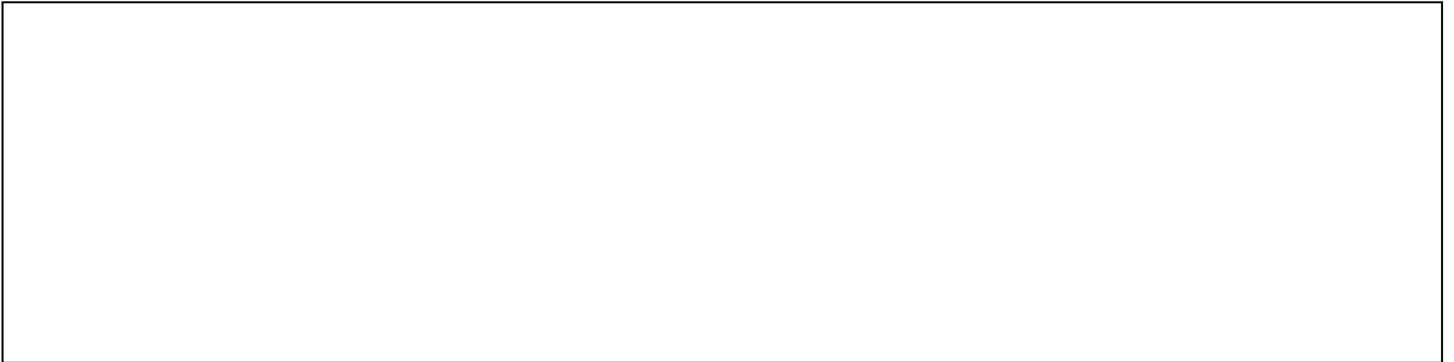
V. What We Can Do About It – Practical Action, Attainable Goals.

“Are we really powerless or do we just feel that way?”

- **Activism and a Changed Mindset**
- **Educating Payors: Traps to Avoid**
- **Legislation**
  - **Alternative Delivery Models**

ACTIVISM AND A CHANGED MINDSET

Where to start. What needs to be done, besides rallying and pointing to the deficiencies of the current system?



IMMEDIATE OBJECTIVE

CONTEXT MUST BE UNDERSTOOD

Seize the opportunity that has recently emerged but be realistic.

- **There is a widely held opinion that health care delivery is not fair or even particularly good when delivered under the managed care paradigm.**

- **Yet, there was so much abuse not only by insurance carriers but by some providers prior to managed care that no one who pays the bills is going to allow the providers to control the system.**

Therefore, neither a system that can reward for over-treatment nor one that can reward for denial of care should even be considered as a basis for moving forward.

- Moreover, mental health and chemical dependency coverage, if carved out will always be the unwanted step-children of health care, ineffective and kept barely alive to feed that rationalization that "… something is being done…".

INTENTION WILL BE THE ORGANIZING PRINCIPLE

PATIENTS FIRST

- **The right care the first time.** Research based wherever possible.

- **Good outcomes.** Measurable outcomes against stated goals reported by patients to an objective third party.

- **Reasonable cost.** Based on how much it really costs to help one patient achieve an acceptable outcome considering relapse and rates of re-occurrence.

OVERALL STRATEGY

Consumers and providers of mental health care need to be armed. A sling shot won't work against a scud missile. Here's a start :

1. **Unite politically.** First with each other and then with the mental health organizations. And speak with one voice. The mental health and chemical dependency fields have a history of bad mouthing themselves and others in the treatment of behavioral health.

2. **Get involved totally in the issues of health care finance and accountability** – private and public. Stop letting our eyes glaze over and allowing ourselves to be bored when the issue of health care financing is discussed. It's our life blood – without it we die.

3. **Stop pretending that we can survive without performance accountability** – real accountability that honestly looks at:
    - Clinical outcomes
    - Performance Audits
    - Benefit to Cost ratios
    - Comorbid impact of untreated mental health issues on overall medical and productivity costs.
    - General neglect in accurately diagnosing and effectively treating chemical dependency.
    - Clinically based treatment cost paradigms.

4. **Educate benefit managers in the economics of the PARETO group** – that 15% of enrollees who represent 75% to 80% of medical costs, and are fraught with behavioral health problems – mainly chemical dependency, depression and anxiety – which will continue to drive medical costs through the stratosphere if they are not properly treated.

5. **Focus on the real cost savings potential**. Emphasize that in a system where 96% of the cost is medical/surgical and 4% is mental health/chemical dependency, further squeezing the 4% will not solve the problem – instead it will make it worse.

6. **Stress the huge cost of the failure to properly address co-morbidity**. Our estimates show that untreated chemical dependency and mental health issues drive 34% to 50% of medical surgical costs, minimum.

7. **Use the media on an ongoing basis**. Transparency lights the pathway to accountability. The media are constantly looking for good stories and for the most part, have sided with our concerns against managed care.

8. **Support the development of new paradigms of cost worthy advocacy** designed to assure the right care, the first time at a reasonable costs through a system that integrates behavioral and medical care at the diagnostic, case management, treatment, and after-care phases of care.

EDUCATING PAYORS: TRAPS TO AVOID

- **“Let’s treat only the most severe cases!”**

Problem 1. The most severe 15 percent are likely to represent roughly 65 percent to 80 percent of the total cost of the plan.

Problem 2. The disorders of those not treated at the earlier stages will progress until they, too, are among the “most severe” cases. Not only will the mental health issue be more expensive to treat, but it will have an increasing adverse comorbid impact on the cost of resultant medical/surgical disorders.

- **“Let’s reduce provider fees – we’ll save millions!”**

Problem 1. This is self-defeating. The most capable therapists will not accept lower fees. The plan will be left with the least experienced, least competent practitioners treating the most difficult, complex cases.

Problem 2. New people will be discouraged from coming into the treatment field. Because overhead expense remains constant, every dollar of fee reduction results in about two dollars less in taxable income. For example: an MSW at $90 per hour will have a taxable annual income of roughly $75,000. At $55 per hour taxable income drops to about $30,000 per year.

Problem 3. Recovery rates will be adversely affected, requiring additional and more costly future treatment while the cost of comorbidity mounts on the medical side.

- **“To contain costs let’s just turn it over to a managed behavioral health care company – let them take the risk!”**

Problem 1. Disavow yourself of the notion that a managed care company will assume anyone else’s risk. The employer and its enrollees will always bear the ultimate risk.

Problem 2.* The MBHO will consume between 45 and 65 percent of the allocation for administrative loadings and profit, leaving half or less for direct care.

Problem 3. The customer will never get the kind of clinical outcome or benefit to cost data it will need to determine the program’s costworthiness, i.e.: clinical effectiveness combined with fiscal integrity.

Problem 4. Because so much less will be spent on direct care, access rates and recovery rates will plummet resulting in repeated treatment for mental and substance use disorders, the comorbid impact on medical surgical costs will be higher, and adverse social effects on the job, in school and in the community will increase.

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* Both the medical/surgical and mental health plans can be effectively administered for less than 5 percent of overall costs, plus claims processing. A single risk pool will result in lower claims due to the elimination of anti-selection practices of HMOs and insurance companies.

LEGISLATION

- **Mental Health *AND* Chemical Dependency Parity.**
  Comorbidity alone should indicate the need for both issues to be included in any parity legislation. But, beware of the fine print: parity legislation that requires providers to be enrolled in a managed care network is fraught with problems.

- **Loss Ratio Legislation.**
  Legislation that requires MBHOs to disclose the percentage of premium that is actually spent on direct care has been enacted in Maryland and Vermont. It gives employers and consumers a

better opportunity to make informed choices when considering entering into a contract with an MBHO. Maryland and Vermont already have such legislation.

- **Priviledge**
  Legislation that requires that anyone working for an MBHO that can authorize type, level or length of care for patients must at least the same education and experience level of the providers who are treating the patients.

- **No Tax Breaks for MBHOs.**
  In the State of Maryland, MBHOs enjoy corporate tax waiver that puts millions into their coffers each year. When legislation was introduced to correct this, only OPEIU CSW Guild 49 was present to testify on its behalf, while the insurance industry was out in full force.

- **Collaborate to Oppose Uniform Accident and Policy provision Laws (UPPL)**
  The American Society of Addiction Medicine of the AMA and the National Conference of Insurance legislators (NCOIL) are working to repeal these laws, but they can use your support. In some states care must be taken not to open "Pandora's Box" on this issue, but in other states, open and active opposition can help to repeal the UPPL.

ALTERNATIVE DELIVERY MODELS

- ### Direct Contracting

This year health care will cost Americans more than 1.5 trillion dollars, or about $5300 per person. About 54 percent is spent in the private sector with the remainder funded through public dollars.[3] Driving a major portion of this expense are unrecognized, untreated behavioral health disorders.

In analyzing health care claims, JWA[4] has found that there is a Pareto group consisting of 15 percent of the claimants who generally consume 75 to 80 percent of the dollars paid. A closer

[3] U.S. Department of Health and Human Services, CSAT/CMHS "Health Care Spending: Mental health and Substance Abuse Treatment 1997" , July 2000.

review indicates that about a third of these claimants, or 5 percent consume 50 to 70 percent of the Pareto group dollars or about half of the overall health care expenditures for the enrollee group as a whole. When tracked over a two to three year period, behavioral health and life style problems emerge as the major underlying cause of these expenditures. Yet, behavioral health issues are rarely diagnosed and treated at the time medical surgical procedures are provided for the acute medical problems they cause.
Three factors that contribute to this are:

(1) lack of adequate physician education on addictions and mental illness;
(2) an emerging practice model driven by managed care which has reduced the time physicians spend directly with patients to seven to ten minutes;
(3) wide spread use of branch logic instead of matching broad based knowledge with symptoms elicited from a comprehensive diagnostic tool.

The key to containing health care costs, will not be found in vain attempts to manage all enrollees in the same way through benefit plan limits, deductibles and co-payments. While these can be important, by themselves they are generally ineffective unless the plan is designed to assure the provision of the right care, the first time at a reasonable cost. This requires an initial comprehensive diagnosis of the patients' problems, referral to appropriate types and levels of care, and an effective follow-up/aftercare system, all based on personal responsibility and delivered in the context of an integrated health system that addresses both behavioral health and medical surgical disorders. Unfortunately, this rarely occurs anywhere in the U.S. health care system, although pilot projects are showing very promising results.

Nationally, the percentage of health care dollars expended on mental health and substance abuse in the private sector declined from about 8 percent to about 3 to 5 percent from 1988 to 2000. For Federal Government employees the drop was even greater – 8 percent to 2 percent.[5] But, this does not tell the whole story. This reduction has come primarily as the result of turning mental health and substance abuse treatment over to Managed Behavioral Health Care (MBHO) firms, which take between 45 and 63 percent off the top for administration, debt reduction and profit, versus 15 to 22 percent for medical HMOs. The reduction in *direct care* expenditures from 1988 to 2000 is more like 5 to 7 percent vs. 1 to 2 percent for both mental health and chemical dependency treatment, with chemical dependency receiving about one seventh of that amount. Employers generally use one of three mechanisms for providing behavioral health services to employees and families:

1. **Medical HMOs**, which largely restrict and deny behavioral health care to ineffective levels.
2. **Indemnity insurance plans** which, while having potentially generous plan limits for medical surgical disorders, have not typically covered behavioral health appropriately and they have largely disappeared from the scene.
3. **Managed behavioral health care (MBHO) systems** using either at-risk carve-outs which function as HMO's, or pre-authorization, case management and utilization review procedures. Both of these approaches can add greatly to administrative costs while seriously restricting care, adversely affecting employee relations and exacerbating medical surgical health care costs.

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[4] JWA (J. Wrich & Associates, Inc.) is a health systems performance company that has conducted performance audits of MBHO firms who provide service to roughly forty percent of the 170 million people currently covered. Moreover, we have reviewed the practice guidelines, placement criteria, continuation of stay and discharge protocols, and the network development procedures of MBHO firms who represent roughly 80 percent of the covered enrollees.

[5] American Psychiatric Association, Institute on research and Education, Darrel Regier, M.D. U.S. Senate testimony 07/11/01

Of the three systems, managed behavioral health care now dominates, covering more than 75 percent of the nation's population. Our reviews reveal critical defects in the way much of this care is managed. These defects are of such magnitude that they make possible a potential market for a new approach to providing behavioral health care which would be both more effective clinically and less costly. Direct contracting.

ALTERNATIVE

In "at risk" carve-outs JWA's audits have shown that the administrative and profit loadings of MBHOs can range from 45 to 63 percent of the employers' premium for behavioral health services. Even in an efficiently managed MBHO these costs are likely to approach 35 percent. Moreover, administrative services could be much more useful to customers at a fraction of the cost. A integrated coalition of a major chemical dependency treatment providers, high quality mental health practitioners, and an independent administration entity (ABC,Inc.) would provide significant improvement in treatment, administrative services and overall cost to employers.

A case in point is illustrated in one of our audits. The customer had spent $105 million during a twelve month period for health care with $10 million going for behavioral health. They issued an "at risk" carve-out contract to a major MBHO firm for $7 million per year. The MBHO firm then authorized roughly $2.4 million per year in actual treatment or only 34 percent of the premium paid by the employer. However, even if the MBHO had paid out $4.5 million, or 65 percent, a ratio few MBHO firms reach in our experience, ABC, Inc through a direct contract for service could still have done much better, in both service to patients and cost to employers.

COST

Here is a comparative analysis based on the premise that an employer would be willing to spend six percent to seven percent of its health care expenditures on behavioral health care.

	CUSTOMER'S ORIGINAL INDEMNITY PLAN TX/Admin: 100/0	CUSTOMERS ORIGINAL MBHO PLAN TX/Admin: 34/66	CUSTOMERS IMPROVED MBHO PLAN TX/Admin: 65/35	ABC, Inc DIRECT CONTRACT TX/Admin: 88/12
TOTAL COST	$10,000,000	$7,000,000	$7,000,000	$6,000,000
Direct Care	10,000,000	2,400,000	4,500,000	5,280,000
Management	0	4,600,000	2,500,000	720,000

TREATMENT

The estimate above shows the improvement only in the overall cost: i.e., reduced premium *and* increased dollars for direct care. The actual amount of increased treatment delivered would be even greater than the seventeen percent ($5.3 million to $4.5 million) increase in the direct care allocations.

- First, the cost of CD/MH practitioner service, devoid of all the paper-work and unnecessary decision justification demanded by MBHO's would free-up more money for direct treatment.

- Next, the immense expenditures connected with utilization review and treatment authorization would not be incurred.

- Finally, the absence of debt resulting from mergers and acquisitions would free up more money for direct care.

- Therefore, the actual number treatment units provided could be as much as 50 percent greater.

Because participants would have a better chance of receiving the right amount and level of care, the outcomes will be significantly improved in terms of both the remission of the clinical disorder and the reduction in co-morbid medical costs.

ADMINISTRATION
On the administrative side, the customer could be provided with much more meaningful service than any of the MBHOs presently provide. This could consist of :

- An initial analysis of medical claims to assess the co-morbid impact of unaddressed behavioral health problems in the enrollee group.

- Ongoing audit of clinical and administrative performance of the treatment providers.

- Pre/post tracking of participants' medical costs and time-off from work.

- Independent validation of the ABC, Inc. provider's outcome evaluation.

- Placement and continuation of care criteria for both chemical dependency and mental health services that assure costworthy care.

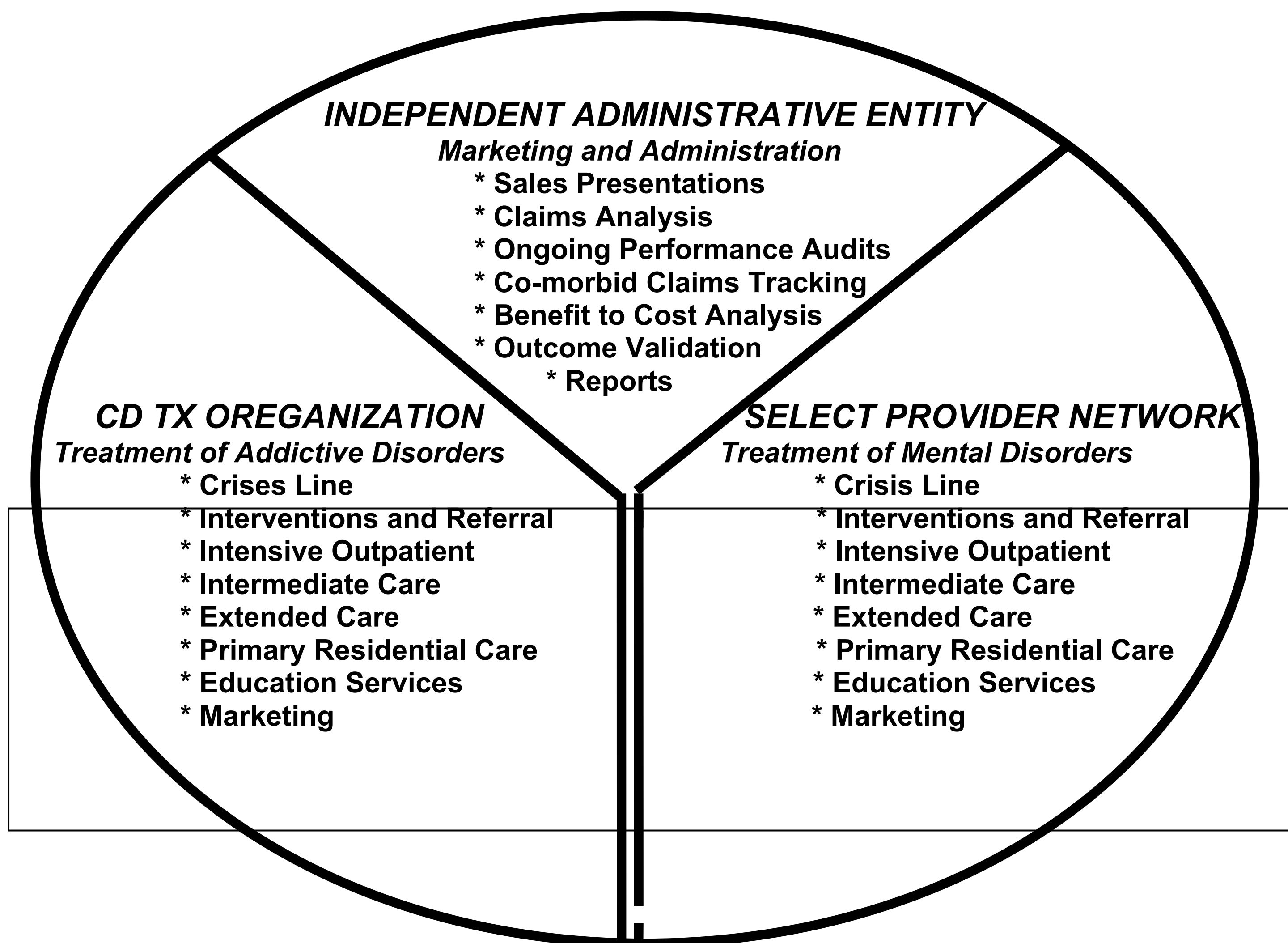
- The usual claims and utilization data would also be provided to the employer.

- The entire service would be subject to an annual benefit to cost analysis based on predetermined variables and goals.

- Outcome goals could be pre-established with financial penalties if they were not met.

THE CONCEPT -- OPERATIONALIZED
A combination of the chemical dependency treatment program's expertise and that of the select mental health provider services would be direct contracted as a behavioral health package with private sector employers. A firm fixed price contract with performance and service parameters to deliver a specific range of services to a specific number of patients would be developed with a provision for adjustments for variances. In this way the providers would not be at risk.

We believe that a very effective story can be told to prospective customers based on the impressive outcomes many of the major chemical dependency treatment organizations have demonstrated over the past 30 years. By tying the favorable benefit of these outcomes to the employers' medical surgical costs and demonstrating significant reductions, ABC, Inc. would simultaneously address the customers' pre-eminent concern about cost while providing information and management controls that none of the health care providers -- medical or behavioral -- has done to this point.

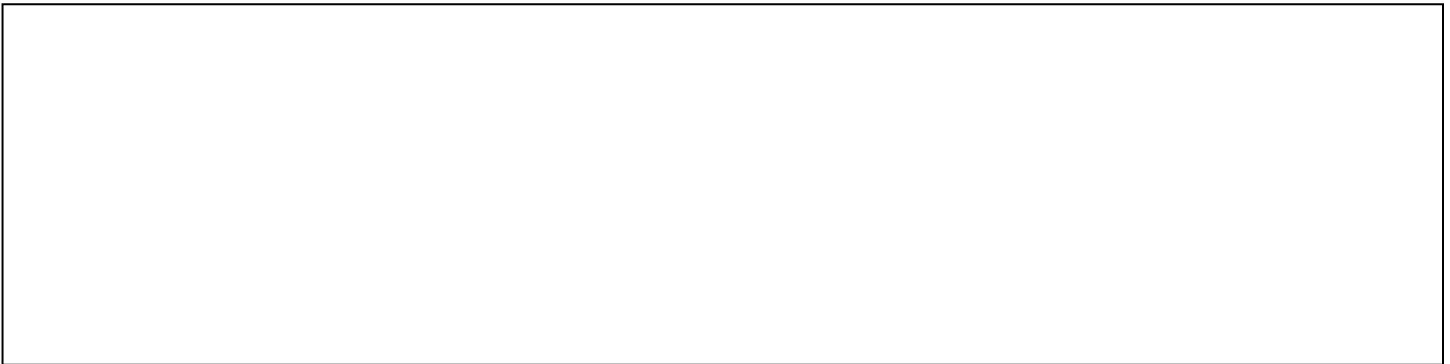


ABC, Inc's outcomes would be shared with prospective customers along with an analysis of costs and results comparing this approach with those currently used by MBHO firms. At the same time, because of the ongoing performance audits and outcome evaluation, the customer would know that any defects would be identified, shared and addressed The only way to continuously improve any system is to audit it, report the findings and recommendations to the customer and make adjustments as appropriate.

The independent administrative entity would provide quarterly reports to the customer and service providers in which performance would be assessed in all critical areas. Recommendations geared towards improving outcomes and the benefit to cost ratio would be included in the reports. An annual report assessing impact of these treatment services on overall health claims of participants would be provided.

POTENTIAL CUSTOMERS

Considering the direct and indirect relationships the treatment providers now have with private employers, there is a significant potential market.



- **The Solidarity Integrated Health Advocacy Program. (SIHAP)**

ALTERNATIVE DELIVERY MODELS