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Managed Care and the Mental Health Professions: History and Effects on Outpatient Care

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The purpose of this article is to offer a brief review of how managed health care companies have affected mental health services. An abbreviated history of these organizations is given followed by a discussion of how they operate to reduce both costs and service utilization. The consequences of their practices on outpatient treatment are then examined. Results indicate that the overall breadth and quality of outpatient services available to the public have been substantially reduced by managed care. Furthermore, clinicians themselves have been harmed by having to accept onerous administrative, economic, and ethical burdens because of managed care policies. The article concludes with suggestions on how to remediate some of these deficits in care and adjust to future challenges.

The rapid growth of the managed care industry has indelibly changed the face of medicine over the last 30 years and nearly every facet of the health-care industry has been affected. Physicians have had to abandon their role as the sole decision maker in treatment and adopt one in which the market partially determines who receives care (Agrawal & Veit, 2002). Pharmaceutical companies, too, have had to make radical adjustments to their business practices including regularly negotiating with third-party payers for medication, accepting increased pressure to sell generics, and directing marketing away from doctors and towards patients (Pollard, 1990). Lastly, the medical insurance industry itself has changed as large free-market managed care plans have gradually eclipsed smaller, individualized health insurance options offered through employer benefit programs (Scofea, 1994). In the midst of these paradigmatic shifts in health care delivery and finance, one particular group often gets left out of discussions regarding the future of medical care in the United States: those who treat mental illness.

As this paper demonstrates, psychiatrists, psychologists, and other non-physician mental healthcare workers have also endured sweeping changes in their clinical practice. In general, the results of these changes have not been well-received; commentary from these groups about managed care has been overwhelmingly negative both in academic journals (Appelbaum, 2003; Watt & Kallmann, 1998) and in the public media (Sharfstein, 2001). One should note, however, that there are some advocates of the managed care system who argue that it provides necessary cost containment without any diminution in quality of care or patient satisfaction (Broskowski, 1991). Still others make the case that managed care companies are unfairly maligned for ethical dilemmas that have always existed in medical practice in different forms (Meyers, 1999). Yet, such defenders of the current health care system are generally rare among mental health care providers. In order to understand the reasons for this, the current paper presents a brief overview of the history of managed care in the United States and typical strategies that these companies use to reduce health care utilization and costs. Criticisms of the current mental health system by psychologists and other practitioners are then examined with special emphasis on the effects of managed care on outpatient psychotherapy. Finally, strategies to either combat or adjust to ongoing changes in the mental health field are discussed. Overall, there seem to be considerable drawbacks to managed care from both the perspective of mental health workers and their clients. It is important that clinical psychologists recognize the extent of these challenges and seek opportunities for continued growth in the field of applied psychology.

History and Structure of Managed Care

While public discourse about managed care has become increasingly shrill in recent decades, the practice of providing pre-paid, group health care is not new. Kaiser Permanente, currently the largest health maintenance organization (HMO) in the United States, originated in the 1930's when a group of physicians were contracted to provide comprehensive medical services for employees working on the Hoover Dam. Similar plans were also put in place to cover the healthcare needs of employees in the lumbering, mining, and farming industries in various parts of the country during the Great Depression. All these forerunners of modern HMOs shared the common features

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of contracting with a limited number of clinicians for standardized fees, usually paid in advance (DeLeon & VandenBos, 1991). Unlike current managed healthcare organizations, however, these practices were often limited to certain commercial and federal employees and were mostly delivered by non-profit organizations. Enrollment in these plans was further limited by aggressive lobbying by the American Medical Association. By the 1950's, pre-paid plans accounted for only a small fraction of the health insurance industry (Broskowski, 1991).

All this began to change after the passage of the Health Maintenance Organization Act in 1973 under the Nixon administration. The law provided federal funds for the establishment of HMOs if they met certain criteria for the program. The legislation was initially passed and later amended to curb the burgeoning costs of healthcare, which had steadily increased to approximately 11% of gross national product by 1987 (Broskowski, 1991). Prior to the passage of this bill, hospitals and clinics had had little incentive to operate efficiently or to invest in preventative medicine because most procedures were covered by traditional indemnity insurance plans in which medical procedures were paid for on a fee-for-service basis rather than through a single upfront fee. Investment in increasingly expensive equipment and technology by health care providers was also problematic, especially when more cost-effective means for treatment existed. As such, one of the major objectives of the new law was to streamline the delivery of healthcare, using such methods as treatment authorization by third-parties, periodic review of clinician performance and financial incentives to lower costs – all methods currently employed by HMOs. Seeing a possible avenue for financial reform already in place, legislators merely sought to encourage HMO growth. One of the ways they attempted to do this was by extending the proposed grants to for-profit companies. Managed care companies grew substantially throughout the 1980's as business and insurance leaders sought to take advantage of these and other economic incentives such as lucrative contracts to provide services for Medicare. This growth has been so rapid that as recently as 6 years ago an estimated 175 million Americans, or about 58% of the population, were enrolled in some form of managed health care (Sanderson, 2004).

Soon after the passage of the 1973 HMO act, other institutional forms of managed care grew up alongside HMOs, including preferred provider organizations (PPOs) and independent practice associations (IPAs). While the details of the care packages offered under these plans differ somewhat from those of traditional HMOs, all three organizational types share common features. First, managed care plans use a pretreatment authorization process to assess whether medical care is warranted given a patient's presenting complaint. Authorization is typically performed by a primary care doctor or sometimes by a non-physician case manager. In insurance parlance this person is referred to as a "gatekeeper" because he or she essentially controls the flow of patients to healthcare specialists that practice outside the "gates" of routine medical care (Richardson & Austad, 1991). Mental health professionals are considered a part of this latter category of providers. Once the decision has been made to treat a patient, the specialist may then be asked to present a treatment plan to a utilization review committee either before or during the course of treatment. The committee will often request that changes be made to the treatment protocol, especially if alternate treatment methods can be used in a time-limited and inexpensive manner. Depending on the committee's recommendations, the patient may receive only a small portion of the benefits to which they are entitled by contract. Another common aspect of managed care insurance plans includes the payment of practitioners via capitation, in which hourly rates per patient are predetermined. Fees may also be withheld based on how cost-effective clinicians tend to be.

Outpatient and Brief Therapy

The economic policies mentioned above create potential barriers for patients seeking treatment for psychological disorders. Perhaps the most severe effects have been felt in the realm of outpatient psychotherapy services. Although federally chartered HMOs are mandated to offer up to 20 sessions of outpatient psychotherapy per year (Richardson & Austad, 1991), many patients receive far less. In fact, data indicates that most beneficiaries receive closer to 6 sessions per year and clinicians have even reported being explicitly told to drop patients within this time frame by their managed care company (Karon, 1995). Data from a national survey of outpatient psychotherapy utilization in 1997 paints an even more dismal picture: only 10.3% of psychotherapy users made more than 20 visits to a therapist and approximately one-third of psychotherapy patients received only one or two sessions (Olfson, Marcus, Druss, & Pincus, 2002). Although unethical coercive practices of prematurely dropping patients are barred, the dual processes of pre-authorization of treatment and utilization review are enough to limit participation in outpatient therapy. Many patients have reported being told by their primary care physicians that their psychological distress did not constitute a "medical necessity" – that is, it was not severe enough for referral to a mental health professional (Miller, 1996). Conversely, other incidences have come to light in which a patient's disorder was deemed too severe to benefit from the limited treatment available through the managed care plan, in which case he or she would be forced to pay out of pocket for specialists (Donovan et al., 1994). Regardless of the ostensible reason for the denial, it seems clear that outpatient psychological services have been singled out by managed care companies for cost containment initiatives. Psychologist Lee Hersch hypothesizes that this effort to cut outpatient care stems from both skepticism among corporate and insurance leaders about the value of

psychotherapy and the difficulties of demonstrating easily quantifiable outcomes among patients (1995). Both objections are questionable and, moreover, do not represent good fiscal policy on the part of insurers. Considering the vast difference between the costs of inpatient psychiatric hospitalizations and less expensive preventative methods like outpatient treatment, the latter should be preferred. Savings from increases in productivity and functionality among patients (known as "medical offset") may also accrue during the course of longer-term treatment. Still, in the absence of hospitalization, patients who give up on therapy or go elsewhere to seek treatment represent a financial success for most managed care companies.

Mental health consumers are not the only ones affected by the effort to restrict or deny outpatient therapy. Substantial changes are also beginning to take place within the psychotherapeutic community that treats managed care patients. The limitations on session frequency and duration have created a shift in emphasis away from long-term therapy toward shorter courses of treatment. As such, the practice of "brief therapy" has emerged as a treatment modality in its own right, distinct from the traditional therapies that preceded it. In other words, brief therapy is not just long-term therapy condensed into 10 or 20 sessions, but represents a significant shift in the overall delivery of treatment (Miller, 1996). Although the techniques and theories underpinning brief therapy are beyond the purview of the current paper, they involve more direct intervention on the part of the therapist and focus on specific treatment goals such as symptom reduction (Charous & Carter, 1996). This does not necessarily imply, however, that all brief therapies eschew strategies from insight-based treatments. Even so, the practice of insight-oriented therapies is becoming less common under managed care because such treatments are not well-suited to the utilization review process (Charous & Carter, 1996). To many clinicians and academics this may not represent a problem because meta-analyses have shown that short term treatments are often just as efficacious at alleviating psychological disorders as long-term psychodynamic therapies (Luborsky, Digeur, Luborsky, & Schmidtco, 1999; Luborsky et al., 2002). Still some evidence exists that for certain patients, particularly those with comorbid conditions, chronic psychological problems or personality disorders, long-term psychodynamic psychotherapy provides superior results (Leichsenring & Rabung, 2008). Managed care providers, on the other hand, are more likely to offer such patients group and educational interventions due to their potential cost-savings when compared to individual therapy. Medication is also a frequent component of treatment because it requires minimal supervision, thus saving time on the part of managed care clinicians and staff. While the efficacy of medication for treating psychological conditions is generally beyond dispute, solely treating patients with pharmacotherapy may raise other issues such as lack of physician supervision, medication non-compliance, and increased risk for prescription drug abuse.

A common complaint about the "brief therapies" is that they are standardized, one-size-fits-all treatments that do not sufficiently address individual differences among patients. Therapists argue that both the limited number of sessions and the sometimes constrictive treatment protocols result in poor outcomes. A cursory glance at research on the typical course of therapy in the U.S. would seem to confirm this conclusion: the median number of sessions per visitor to a mental health practitioner between 2001 and 2003 was only 7.4 (Wang et al., 2005), yet studies estimate that an average "dosage" of between 11 and 19 sessions is needed to achieve a modest 50% rate of improvement (Anderson & Lambert, 2001; Kopta, Howard, Lowry, & Beutler, 1994). As Ivan J. Miller (1996) has pointed out, patients are most susceptible to the placebo effect in the early course of their treatment and thus there is little reason to believe that such small "doses" of therapy are actively producing change. Moreover, it is likely that patients who are not "rapid responders" experience more serious disorders which are not appropriate for brief treatment. These patients, who would benefit the most from therapy, are therefore the least likely to receive a sufficient amount of it. Ultimately, the only way to determine whether brief therapy is effective is to consult outcome and efficacy studies. Psychological literature provides contradictory evidence, however, with some studies showing efficacy equal to that of long-term therapy and some showing reduced or non-significant efficacy (Plante, 2005). Until further studies are done, the success of most outpatient therapies in managed care settings will remain unclear. More troubling is the fact that the existing brief therapy research focuses on interventions that last from 25 to 30 sessions (Miller, 1996). The services that managed care offers are often in the "ultra-brief" range, defined by Ivan J. Miller as no more than 6 sessions (1996). To the author's knowledge, there are currently no controlled studies of this type of therapy.

Difficulties for Clinicians

In addition to concerns over the effectiveness of managed care treatment, many mental health workers experience stress related to increased ethical, administrative, and economic burdens. Ethical concerns may arise because of divided loyalty between third-party insurers and patients. Psychologists employed by HMOs, for instance, might be forced to follow a treatment plan that is inappropriate according to his or her clinical judgment and, as mentioned earlier, may even be pressured to discontinue treatment. Practitioners who contract with insurers as independent agents (IPAs, PPOs) can encounter similar ethical dilemmas as they attempt to ensure their own financial stability. Employees who are paid via a capitation system are particularly vulnerable to conflicts of interest since they assume most of the financial risk associated with treating clients. In an environment where cost-containment is of such paramount importance, it may be difficult for

clinicians to balance the financial limitations imposed on them by insurers with the needs of their client base.

Onerous administrative responsibilities such as having one's professional decisions reviewed by primary care providers can also provoke feelings of bitterness between parties in the managed care system. The utilization review process involves intense scrutiny of a clinician's work, often by case managers who lack the same professional credentials as the person whom they are reviewing. Although it would be easy to accuse high-level practitioners of mere vanity, medical doctors and PhD's do, in fact, resent having their decisions second-guessed by administrative personnel employed in business related settings. Confrontations can be a frequent occurrence. A study by Ronda Callister and James Wall Jr. (2001) showed that health care practitioners employed by managed care companies are highly susceptible to anger and may engage in retaliatory behavior such as poor collaboration and refusals to compromise. Callister and Wall found that a key determinant in the development of conflict between clinicians and case managers was the disparity between the professional prestige of the individual parties and that of their respective organizations. Interactions were most likely to become hostile between high-status clinicians who worked for weak institutions (like small private practices) and low-status case managers in powerful insurance organizations (Callister & Wall, 2001). In such instances, individuals are caught in "power asymmetric" relationships in which each side seeks to manipulate the other according to different power criteria. In the end, the person with the least organizational power usually ends up capitulating – typically the clinician (Callister & Wall, 2001).

Future Directions

Despite the vicissitudes that both mental health consumers and providers face in dealing with managed care in the U.S., there are ample opportunities to adjust to and even benefit from current changes in health policy. In his article on adapting to modern health care reform, Lee Hersch has outlined three basic strategies that current and future clinicians can use to ensure that the field of applied psychology will continue to flourish in the 21st century (1995). The first two approaches are top-down strategies that seek to bring about change through legislative, judicial, and regulatory interventions. First, he supports lobbying for parity with respect to government spending on psychological disorders in comparison with other medical conditions. Second, he encourages APA members to support political candidates will be likely to endorse such initiatives. Clinicians should also work with receptive politicians to create laws or sue for judicial rulings which require increased transparency from managed care companies. One of the greatest impediments to an accurate assessment of the managed care system is the lack of both empirical and anecdotal evidence regarding its practices. Adequate information for the comparison of managed care plans remains inaccessible, even for insurance industry surveys (Miller, 1996). Prospective buyers of managed care are often misinformed about the details of the plan and important company policies limiting treatment options are never disclosed. Deficiencies in coverage are often discovered only after medical problems have arisen and consumers have sought funding or reimbursement. With respect to outpatient care, the maximum number of therapy sessions covered in the contract does not accurately represent the number that will actually be received because of "gatekeeper" interference and other previously discussed practices (Miller, 1996). For those practitioners that are not in a position to lobby for governmental action, the resource is to simply express their concerns by voting during state and national elections.

The third strategy that Hersch suggests for improving the quality of mental health care is for clinicians to work toward diversifying the applications of clinical psychology to the medical sciences while simultaneously integrating the delivery of services so that greater coordination exists between providers at all levels of patient care. With respect to diversification, Hersch notes an encouraging proliferation of specialty areas in psychology, especially in fields related to general medical treatment. It is estimated that 60% of doctor visits are due to stress or other psychologically related problems (VandenBos & DeLeon, 1988). It is not surprising, therefore, that psychologists see an opportunity to have a significant impact on the nation's overall level of health. Integration, on the other hand, can be achieved through the creation of multi-disciplinary mental health groups composed of social workers, drug counselors, psychologists, psychiatrists, and other mental health care professionals. This increased coordination of care may better enable clinicians to contract directly with business and industry to provide superior mental health care without the encumbrances of third party insurers. Moreover, these organizations could more easily create working relationships with other medical providers including nurses, pediatricians, OB-GYN's, family physicians, and other primary care physicians.

While managed care has clearly brought about a host of difficulties that affect the quality, delivery, and funding of mental health care, the outlook for future clinicians and patients is not as grim as one might believe. Rather than an obstacle to the future of clinical psychology, managed care can be viewed as a catalyst for much needed changes in the health care system. It is therefore incumbent on psychological professionals to meet the challenges presented by managed care by rededicating themselves to mental health service that combines superior clinical practices with fiscally responsible and efficient methods for meeting patient needs.

References

Agrawal, G. B. & Veit, H. R. (2002). Back to the future: The managed care revolution. *Law and Contemporary Problems, 65*(4), 11-53.

Anderson, E. M. & Lambert, M. J. (2001). A survival analysis of clinically significant change in outpatient psychotherapy. *Journal of Clinical Psychology, 57*(7), 875-888.

Appelbaum, P. S. (2003). The 'quiet' crisis in mental health services. *Health Affairs, 22*(5), 110-116.

Broskowski, A. (1991). Current mental health care environments: Why managed care is necessary. *Professional Psychology: Research and Practice, 22*(1), 6-14.

Callister, R.R., Wall Jr., J.A. (2001). Conflict across organizational boundaries: Managed care organizations versus health care providers. *Journal of Applied Psychology, 86(4), 754-763.*

Charous, Margaret A., Carter, Ross E. (1996). Mental health and managed care: Training for the 21st century. *Psychotherapy, 33*(4), 628-635.

DeLeon, Patrick H., VandenBos, Gary R., Bulatao, Elizabeth Q (1991). Managed mental health care: A history of the federal policy initiative. *Professional Psychology: Research and Practice, 22*(1), 15-25.

Donovan, J. M., Steinberg, S. M. & Sabin, J. E. (1994). Managed mental health care: An academic seminar. *Psychotherapy, 31*, 201-207.

Garfield, S. L. (1986). Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 213-256). New York: Wiley.

Hersch, Lee (1995). Adapting to health care reform and managed care: Three strategies for survival and growth. *Professional Psychology: Research and Practice, 26*(1), 16-26.

Karon, Bertram P. (1995). Provision of psychotherapy under managed health care: A growing crisis and national nightmare. *Professional Psychology: Research and Practice, 26*(1), 5-9.

Kopta, S. M., Howard, K. L, Lowry, J. L., & Beutler, L.E. (1994). Patterns of symptomatic recovery in psychotherapy. *Journal of Consulting and Clinical Psychology, 62*, 1009-1016.

Leichsenring, F. & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association, 300*(13), 1551-1565.

Luborsky, L., Diguer, L. Luborsky, E., & Schmidt, K. A. (1990). The efficacy of dynamic versus other psychotherapies: Is it true that "everyone has won and all must have prizes? – an update. In D. S. Janowsky (Ed.), *Psychotherapy Indications and Outcomes* (pp. 3-22). Washington, DC: American Psychiatric Press. Luborsky, L., Rosenthal, R. Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., et al. (2002). The dodo bird verdict is alive and well – mostly. *Clinical Psychology – Science and Practice, 9*(1), 2-12.

Meyers, C. (1999). Managed care and ethical conflicts: Anything new? *Journal of Medical Ethics, 25*(5), 382-387.

Miller, Ivan J. (1996). Managed care is harmful to outpatient mental health services: A call for accountability. *Professional Psychology: Research and Practice, 27*(4), 349-363.

Olfson, M., Marcus, S. C., Druss, B., & Pincus, H. A. (2002). National trends in the use of outpatient psychotherapy. *The American Journal of Psychiatry, 159*(11), 1914-1920.

Plante, T. G (2005). *Contemporary Clinical Psychology*. New Jersey: John Wiley & Sons.

Pollard, M. R. (1990). Managed care and a changing pharmaceutical industry. *Health Affairs, 9*(3), 55-65.

Richardson, L. M., & Austad, C. S.(1991). Realities of mental health practice in managed-care settings. *Professional Psychology: Research and Practice*, 22(1), 52-59. *Psychology, 86*(4), 754-763.

Sanderson, C. A. (2004). *Health Psychology.* New York: Wiley.

Scofea, L. A. (1994). The development and growth of employer-provided health insurance. *Monthly Labor Review, 117*, 3-10.

Sharfstein, J. (2001). Unhealthy partnership: How managed care wrecks mental health for kids. *American Prospect, 12*(1), 24-28.

VandenBos, G. R. & DeLeon, P. H. (1988). The use of psychotherapy to improve physical health. *Psychotherapy, 25*, 335-343.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., Kessler, R. C. (2005). Twelve month use of mental health services in the United States: Results from the national comorbidity survey replication. *Archives of General Psychiatry, 62*, 629-640.

Watt, J. W. & Kallmann, G. L. (1998) Managing professional obligations under managed care: A social work perspective. *Community Health, 21*(2), 40-49.