Economic Determinants and Managed Behavioral Healthcare: Marginalization of Providers and Restrictions of Services

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Abstract

Managed care organizations tend to prioritize finance management over services and, as a result, have alienated providers and diminshed the service delivery system, while profiting handsomely. The managed care strategy of cost-containment is examined as it relates to quality of care, particularly in behavioral health treatment. The problems of excessive manged care profits and administrative overhead are considered in relation to a pattern of misuse of limited healthcare resources. Managed care policies and procedures that reduce healthcare to a commodity are critiqued. The essay's key points for improving healthcare, in whatever systems evolve, are to de-emphasize "commerce" and to resuscitate preferred cultural values regarding "service". Suggestions for reform are made that reflect inclusiveness from a wide range of constituents in healthcare and participatory management principles to redress the imbalance of authority that now rests with managed care organizations.

Introduction

Managed care ranks with deinstitutionalization and psychopharmacology among the most influential innovations in health care policy in the past twenty-five years. Health maintenance organizations (HMOs), preferred provider organizations (PPOs), employee assistance programs (EAPs) and other administrative structures characterize the managed care world and are touted as methods to control costs and to improve quality of healthcare. Some firms manage general *and* behavioral healthcare, while other companies are specifically contracted for behavioral (i.e. mental health and addiction treatment) services only. By the mid-1990s, advocates within the managed behavioral healthcare industry felt that it was "positioned to confer vast social benefits to the American people through its expertise on management" of the service delivery system (Freeman & Trabin, 1995).

Yet a contentious divide exists between many healthcare providers and managed care organizations (MCOs) (Davidson, Davidson & Keigher, 1999). Why the disparity? Much of the problem can be traced to the asymmetrical control of resources by MCOs accompanied by their replacement of "a service ethos with a commercial ethos" (Light, 1994, p. 1198). While key stakeholders in managed care have profited handsomely, their cost-containment measures have reduced services. Insurers, government officials, providers, employers and consumers need now to collaborate in efforts either to reform for-profit managed care, or to replace it.

Domination of providers by managed care organizations

Riffe and Kondrat (1997) observe that "human needs become shaped and invented in accordance with technological imperatives by those who control the technology" (p. 45) and conclude that providers within managed care settings often experience alienation and disempowerment as a result of accommodating managed care policies. Since MCOs set the parameters of behavioral treatment—including who has access to services, who will be on provider panels, the appropriateness and length of treatment, the rules for applying benefits and the dollar limits to providers per units of service—there are strict controls on providers' incomes and upon the way providers work. In the late 1980's through the 1990's, providers experienced the changes wrought by MCOs as fiats from afar.

As extensive, for-profit, managed care plans evolved and became the prominent health service delivery system over the past decade, clinicians and behavioral

treatment agencies were typically left outside the loop of planning and development.[1] MCOs would position themselves in key geographical locations, secure contracts with large employers or government entities (if Medicare and Medicaid monies were available) and then begin the process of recruiting providers in the region as contractees. Providers found themselves needing to agree with the terms of the predominant MCOs in their area, or risk losing present and future clientele, including government contracts. State block grants and private third-party insurance companies all began to funnel monies through MCOs in the 1990s. If providers opted to stay outside of the newly established "system" the prospect of financial failure loomed large on their horizon.

Controls over information processing and casemanagement

As providers lost the option of billing third party insurance directly in a fee-for-service setting, as was characteristic of the pre-managed care era, clinical autonomy was sacrificed, and in some cases, professional values were compromised (J. Davidson & T. Davidson, 1996; T. Davidson & J. Davidson, 1998). This may seem an odd or overly dramatic assertion, unless the inside perspective of the clinician-client relationship is gained. Traditionally, in behavioral healthcare, because the relations between clinician(s) and client(s) were *confidential* and *fiduciary,* with insurers on the outside in a secondary capacity, the therapeutic relationship could evolve without undue interference from the financial center. Managed care brought the insurer in as the comptroller, determining practitioners loyalties and decisions and consumers needs and possibilities.

Case management—and the information processing conducted by the clinician with a client or the client's family— is the heart of behavioral treatment. Before managed care, there were no external jurisdictions for providers other than their professional code of ethics, statutory requirements of their licenses and internal supervisory functions. After managed care, all casemanagement, and the intricacies of the professional rules of conduct that traditionally attended it, were subject to the terms of the contract between the respective MCO and the provider. Financiers ascended to the dominating position in healthcare, without effective checks and balances on business interests versus service concerns.

Presently, information processing between clinicians and clients is transformed from a clinician conferring with clients or their families to "grist for the mill" of industrialized managed care. In taking over the delivery systems of behavioral healthcare, MCOs needed and demanded data from providers. Confidential communication between a clinician and client was the first practice (and value) to go under managed care (T. Davidson & J. Davidson, 1995). Controls over clinical decisions were not far behind. Suicide assessments, decisions to hospitalize, planning for termination of treatment, clinical preferences for the kind of therapy to be employed and definitions of what behavioral disorders are appropriate for treatment have all been subjected to managed care review and authority. Many MCOs even placed "gag clauses" in their contracts with providers to ensure that all information about treatment remained under corporate control—providers could not inform their clients or patients of other treatment options if those treatments were not sanctioned by the MCO. Subsequently the courts have determined that the gag clauses are illegal, but the symbol remains. MCOs, as business enterprises, are intent upon dominating clinicians, as healthcare providers.

Wealth and disparity

In addition, the "benefits" of managed care appear often to accrue in windfall profits to the controlling companies while the subscribers to managed healthplans are denied the very services MCOs are meant to manage. It is not uncommon, for instance, for the benefit package of a managed healthplan to indicate that any given employee could access up to twenty outpatient visits with a behavioral healthcare

provider over the course of a year; whereas the MCO could restrict the actual use of the benefit to one to three sessions.[2]

Meanwhile, in the 1990's (the decade of excess in the profit-driven managed care industry) stocks rose exponentially for many MCOs, capturing The Wall Street Journal headlines with titles like "Money machines: HMO's pile up billions in cash, try to decide what to do with it" (Anders, 1994, p. A1). In 1994, cash and stock awards to the top executives of the seven largest for-profit HMOs averaged $7 million; in 1996, the twenty-five highest paid HMO executives had an annual compensation of $6.2 million and $13.5 in unexercised stock options (Freudenheim, 1995; Pollack & Slass, 1998). In 1999, many publicly traded managed care companies performed poorly in terms of delivering shareholder value; but even so the top earning executive made $1.17 million in salary, $4.28 million in bonus pay and other compensations, as well as several millions in stock options ("1999 HMO Executive Pay," 2000).

During their years of exponential financial expansion, MCOs insisted that their contracting providers submit claims up to a certain limited point only, even if the clinician or agency still judged the client to be in need of further services. Under such circumstances, those in the business of "caring" have often opted to extend treatment as much as possible even though they will not be reimbursed by the MCO, while those in the business of "managing" have rested secure in achieving a designated profit margin. Of course, other providers simply do less because they are paid less. In either regard, the MCO is determining limits, with a view of handsomely rewarding itself when possible, while clinicians and consumers remain beholden to the largesse of the company.

The tale of providers and consumers being vulnerable to the economic controls of the MCOs applies even when the managed care firm declares bankruptcy. Recently, Harvard Pilgrim Health Care (HPHC), Massachusetts' largest and Rhode Island's third largest health maintenance organization, went into receivership (O'Neill, 2000). The MCO, following the standard practice of delaying payments to providers while cases are being reviewed, reached the point where it could not pay its contracting clinicians and agencies at all. Though owed for a backlog of previous services and with no immediate reimbursement for present services, these service providers have been ordered by the court to continue treating old clients and to accept new clients from HPHC. The providers may eventually be paid pennies on the dollar. The new, larger MCO, which is expected to replace HPHC as the primary contractor, traditionally has made its profits in three ways: (1) reducing providers' fees, (2) eliminating healthcare services when possible and (3) decreasing the size of provider panels (O'Neill, 2000). Such "solutions" continue the problem of marginalized providers and minimized services for consumers while the MCOs continue their marketplace competitions.

The value of cost-containment

For all its flaws in undermining service values in favor of corporate insatiability, managed care systems can help the national economy and eventually the healthcare industry by keeping a focus on restricted budgets. Fee-for-service indemnity plans, which were characteristic of insurance coverage before the managed care era, gave incentives to doctors and other health professionals to bill for more services and contributed to runaway healthcare costs on a national level. Valuable lessons gleaned from managed care initiatives are (1) fragmented systems with institutionally biased health facilities are not the best way to deliver services and (2) cost-containment with an emphasis upon efficient outcomes are preferred management methods for serving the public's healthcare needs.

The problem with the strategies of the for-profit, managed care corporations is that the clinical tactics they insist upon often only cloak their own economic goals. The following list of commonplace behavioral treatment policies and occurrences from MCOs are clear ways—not to save

money—but to make money for the controlling MCO as contractor: (1) payments only for specific, narrowly defined, minimal services, irrespective of individual differences in pain and suffering; (2) preset lean conditions for referrals and authorization of services; (3) inconvenient, time-consuming telephone contacts and extensive paperwork requirements from providers; (4) delays in authorizing treatment or in reimbursing providers; (5) remuneration for "gatekeeping" physicians when they dramatically reduce the number of services they give and when they minimize referrals to specialists; (6) opposition to governmental oversight or review by neutral third party consumer groups, regarding MCOs utilization committees and procedures; and (7) resistance to "any willing provider" laws, because once the MCO does not control the provider panel the system is less responsive to the MCO's economic controls.

Such strategies fail in several regards. First, a good portion of the money that is "saved" is merely consumed by the administrative structures and shareholders of the respective MCO rather than invested in healthcare infrastructure. Second, the focus tends to be on "less" care rather than "better" care. Third, "prevention", although often espoused by managed care advocates as a feature of their systems, rarely receives necessary funding or any sustained emphasis from the MCO (which is fundamentally required in mental health and chemical dependency interventions). Fourth, consumers and providers are treated as the "other" to be restricted or suppressed, rather than constituents or partners; MCOs have totally failed to realize the organizational benefits of participatory leadership. Fifth, the tendency of federal and state governments for over a decade has been to look for solutions within the private sector. Government, on both sides of the political spectrum, could be expected to support an industry that would self-impose regulations to take care of patients' rights and provider concerns. But MCOs, as a whole, have fought for deregulation (read: operate with impunity) and concluded that patient rights are too expensive (read: reduce profit margins).

1998 may turn out to be a turning point in how managed care cost-containment principles are understood by employers and the buying public (including taxpayers). The drop in HMO memberships from 50% to 47% of employees in American companies occurred simultaneously with a rise in total employee healthcare costs of 6.1% which ended five years of essentially flat growth as MCOs established economic controls nationwide (Winslow, 1999). These juxtaposed figures illustrate that not only are consumers weary of restrictive type managed healthcare plans, but likewise, that costs will not magically be restrained as corporations satisfy stockholders and providers and consumers react to limitations in services.

Industrial analysts of MCOs observed in the early 1990s that the successes of many managed care plans in spending less for healthcare were based on the practice of risk selection or "cherry picking": employees known by actuarial analyses to be "healthier" and therefore in need of fewer services were the first recruits of managed care, while "sicker" patients were less likely to be enrolled in the managed healthplans (Light, 1992). When the benefits consulting firm of William H. Mercer, Inc. conducted their recent survey of falling HMO memberships, they concluded that the managed care promise—"if you agree we can limit your access, we will give you higher quality care for less cost" (Winslow, 1998, p. B6)—is now being broadly questioned by large employer groups. Once the net of managed care services covers a broader spectrum of the population as it now does, simple restriction policies are not a good way to achieve cost-containment.

Service restriction and behavioral healthcare

In essence, the true cost savings from managed care come from the initial bid with employers or the government. For example, if company A traditionally spent $5,000 per employee on health benefits per year, the bidding MCO might offer a plan to the employer with a guarantee to

cover all employees at $4,750 per year but then only release an average of $2,000 - $3,000 for actual services during that time frame. The rest is managed care profit.

A discounted, service-restricted approach is particularly troubling when mental health and chemical dependency treatment are the needed service. Behavioral treatment is not based upon high technology that a MCO might decrease and thereby save money. Mental illness or addictions are rarely overdiagnosed and therefore a screening visit by a gatekeeping physician is not an effective way to curtail further unnecessary treatment. The hard costs are in the field of service. When those costs are eliminated people simply do not get adequate care. High non-behavioral medical cost offsets and difficult-to-trace social cost offsets typically follow whenever mental health and addiction treatments are cut back.

Before 1989, approximately 80% of the money spent on psychiatric services in the United States came from inpatient treatment (Borenstein, 1996). Effective cost-containment of the future should focus upon various levels of care in inpatient, residential, home-based and acute care, with enough community support to sustain an effective infrastructure.[3] Theoretically, MCOs could oversee this level of network development but to do so would require hands-on management and conjoint planning with providers and consumers, rather than the bureaucracy of remote financial officers with the primary goal of quick profits.

Quality and the commercial ethos

The common wisdom of a capitalistic society is that the buying public will eventually insist upon an acceptable level of quality in whatever product is being purchased, including healthcare. The patient backlash against managed care and the class-action lawsuits by providers which characterize the latter part of the 1990's probably attest to a degree of truthfulness in that wisdom. But MCOs have been particularly adept at securing their profit margins irrespective of service.

Over and again in the 1990's, managed care financial gains were achieved even if adequate services were not provided. To cite a relatively mild example: In 1991, the State of Ohio paid an MCO (American Biodyne) $14 million to cover mental health and substance abuse disorders for the State's employees. The MCO spent $4.7 million of this contract on services and kept $9.3 million for overhead and profits. An independent auditing firm found problems in 30% of American Biodyne's cases, most commonly a failure to "properly evaluate, diagnose [and] treat" (Hymowitz & Pollock, 1995, A4). There were no mental health therapists available in 16% of the counties and no substance abuse counselors in 32% of the counties in Ohio. Only 3/5 of the State employees who were documented by the MCO as receiving treatment were actually served. Despite these objective facts, a spokesperson for American Biodyne argued: "If you overtreat them [i.e. the patients on their healthplans] some others won't get the treatment because of limited resources" (Hymowitz & Pollock, 1995, A4). Even with these publicized failures, three years later, a merged Biodyne/Medco company won Medicaid contracts with another state, Iowa, and major contracts with IBM and Fed Ex. By 1995, the MCO showed such economic promise that the tobacco company, R. J. Reynolds, purchased Biodyne/Medco (Himmelstein, 1996).

When Florida opened the HMO market for Medicaid in the early 1990's, 21 of the 29 plans failed to meet minimal quality standards. Five of these managed care firms had overhead and profits which consumed 51%-77% of their enrollees premiums instead of the money being put into service for the Medicaid recipients (Pear, 1995). While the MCOs were benefiting from taxpayer dollars and operating within a highly deregulated industry, analysts observed that exorbitant lobbying fees were being paid to several state government officials and brokers fees were being drawn from the Medicaid monies (Himmelstein, 1996).

Even when there is a more reasonable distribution of administrative overhead

and service dollars, successful publicly-traded MCOs ensure that profits grow. This understandable feature of for-profit MCOs needs to be kept in perspective in any consideration of managed care as a mitigator for the nation's escalating healthcare costs. Once the competition is controlled or eliminated, MCOs will raise premiums to cover their costs just like any other business would.

In 1996, the MCO with the most assets (United HealthCare) had premium revenues of $8.5 billion, a 72% increase from 1995, which was a 46% increase from 1994. According to their financial report published for that year (Financial Review, 1998), United HealthCare's goal was to control its rate increases on premiums by 1%-2% annually, based upon anticipated costs the company might bear. However, in 1996 the costs were 3%-4% higher than expected. Therefore they raised premiums on renewal rates by 4%-5%. These kinds of rate increases, coupled with fee revenues of $1.4 billion in 1996 (a 42% increase from 1995) attributable to enrollment growth "most notably in the behavioral health and demand management businesses" (p. 4) are characteristic of the development of the leading MCOs as economic powerhouses. By the end of the decade, United HealthCare (d/b/a United Health Group) had $17 billion in annual revenue through six separate health-related groups (Best's Review, 1999).

There may be merit to the viewpoint that MCOs can reduce waste and achieve an economy of scale. However, there are no magical formulae introduced by managed care firms where shareholders can make substantial profits without absorbing healthcare resources that otherwise could be applied to services.[4] When taxpayer dollars are part of the financial mix, in the face of 44 million uninsured Americans, and the pressing need for universal healthcare, the question of the relative good of managed care must be raised by the government and by consumers and then acted upon. Every dollar a MCO controls comes from the benefit package of a worker or from a taxpayer and should be applied judiciously for the personal and public good of consumers.

Conclusion

Much work is needed to improve Twenty-first Century healthcare delivery in the United States. Five key groups are required at the policy planning table to address the problems of the previous decade regarding the economic determinants of managed behavioral healthcare. These include (1) insurers (MCOs included), (2) government regulatory bodies (federal, state and local authorities), (3) providers (represented by professional and licensing organizations), (4) employers (large industry and small business leaders) and (5) consumers (recipients and family members as represented in national and local service associations). One of the key problems with the development of managed care services in the past decade is that most of the power to effect change has rested with the MCOs themselves.

With MCOs acting as the defining voice in driving industry change, there has been a fusion, even a confusion, of the proper role of the insuring and overseeing MCO as contractor, clinical personnel as contractees and government as regulators. Much provider discontent with managed care can be understood by reference to the commonly held belief that the system which unfolded is existing for financial gain rather than to promote a healthy population. The lopsided power differential also resulted in MCOs exercising authority with impunity in too many instances. The end result is an overemphasis by MCOs upon making money—health services as a commodity—and not enough long term focus on prevention, early intervention, continuity of care, community accountability, regional management, strategic treatment designs for acute and long term illnesses, improving outcomes based upon best-practice guidelines and concentrating on the health status of defined populations. Rather, under-utilization of services, denial of care and overzealous attempts to control expenditures are the impressions left of managed care.

Good financial planning is necessary for delivering good behavioral healthcare. But

the profit-driven MCOs, holding the dollars from employee insurance premiums and taxpayer Medicare and Medicaid contracts, tend in two directions: (1) either cut off funding for services as if needs no longer exist or (2) reduce their own risk by setting up capitated contracts with provider groups to solve the problem on their own. Restricted, control-oriented funding or discounted, risk-free funding protect MCOs but do not necessarily result in the best healthcare system.

The new millennium introduces an unusual problem for the few national behavioral MCOs who have taken over the market. After lowering direct treatment costs and buying out competitors, behavioral healthcare on a national level has shrunk to approximately 3% of national healthcare expenditures, down from 8%-12% in the pre-managed care era (Pomerantz, 2000). Earlier predictions suggest the numbers of people receiving services may drop even lower to 1%-2% (Borenstein, 1996). Pomerantz notes that "now that only a handful of companies control the field and supply cost-containment for about 150 million lives, future business prospects appear dim" (p. 2) and argues that the behavioral management companies own self interest may compel them to move to more outcomes-oriented management strategies rather than cost restrictions alone.

If MCOs do put more money into disease management for designated populations with mental illness and addictions, they will have to be more collaborative with providers and consumers. But any policy planning which gives MCOs more authority at this point should be suspect. Organizationally, the gulf between MCOs and providers must be bridged and the power differential redefined if the challenges of better and sufficient care are to be realized on a national level. The key points for improving healthcare in whatever systems evolve, is to de-emphasize "commerce" and resuscitate preferred cultural values regarding "service".

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Notes

[1] By virtue of separate bargaining between MCOs and employers or government agencies, direct service providers with whom managed care entities would eventually contract had little input on the terms of service as managed care was becoming the dominant force in healthcare. For-profit managed healthplans established controls over the field of behavioral services in true corporate take-over fashion.

[2] Once the employee goes for treatment, the all too common response from the MCO's utilization review team invariably is to restrict the number of sessions which that employee is allowed to receive, claiming that further treatment would not comply with the healthplan's definition of medical necessity.

[3] Inpatient facilities need to be tied into the local communities continuum of care, with flexible admission and discharge procedures, and with blurring of the organizational lines between inpatient and outpatient providers, to allow for thoughtful, well-timed "step up" (more intensive/restrictive) and "step down" (less supervision/protection) treatment options.

[4] The issue for national health policy planners is to determine the value of the administrative function of MCOs, in view of the services that will go underfunded once monies are placed in these corporations.