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Managed Care: "It's like déjà-vu, all over again"

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A majority of Americans with health insurance are covered by managed care plans. Managed care as a form of health care delivery and reimbursement is the most recent of a long line of private sector alternatives to government backed national health insurance (NHI). This article reviews the recent history of health care insurance with special attention to reimbursement for mental health services. Finally, a brief discussion is offered concerning the potential benefits of managed care and future developments in the health care marketplace.

"If Sigmund Freud were alive today, he'd be turning over in his grave." This quote, attributed to Yogi Berra, expresses what nearly all providers of mental health care know—that there has been a revolution in the financing and delivery of mental health care within the last two decades. Variously praised and reviled, managed care plans are the primary means for most employed Americans to get their mental health care, covering nearly 169 million out of the estimated 223 million people with health insurance ("Who says...," 1997). These enrollment figures are a nearly 100% increase in participation in just the last three years.

Managed care is hardly without its critics. For instance, Wright (1991) suggests that managed care requires the rationing of health care, with very little cost savings. Mental health professionals often complain about additional documentation, low reimbursement rates and potential confidentiality compromises. On the other hand, supporters suggest that managed care plans have truly slowed cost increases while access to care has been enhanced (Cummings, 1991).

Is managed care the problem in today's marketplace for mental health services? Or have mental health professionals generally been unprepared to deliver cost-effective, market driven solutions to rising costs of health care? Asked simply, is managed care the problem or the solution for what is wrong in the financing and delivery of health care? This article suggests that managed care is neither the problem nor a lasting solution to the issues in health care. I submit that managed care is one in a line of arrangements which have evolved during this century to lessen the financial and health risk of living in an increasingly mobile, secular and dangerous society. Furthermore, opponents of national health insurance (NHI) proposals have historically appealed to private sector innovations such as managed care to counter efforts to federalized health care. As the sage Berra said in another context, managed care is "like déjà vu, all over again."

As a market oriented approach to the financing and delivery of health care, managed care principles have been embraced by business owners as a means of cost control (Geisel, 1995). As noted above, providers of care are divided on the benefits of managed care. While a number of observers believe managed care and psychotherapy are incompatible (Litvak, 1994), I will argue that managed care has

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generated some modest benefits in its courtship with behavioral health. Finally, despite the benefits, I contend that any form of health care system will be subject to corruption and exploitation unless incentives to commit fraud are balanced by stronger incentives for all concerned to maximize beneficial health outcomes.

Insurance: The Search for Security

To demonstrate that managed care is one of several private sector deterrents to NHI, a brief description of the nature and history of health insurance is important. Insurance is "a formal social device for the substitution of certainty for uncertainty through the pooling of hazards" (Eilers, 1963, p. 3). Insurance is a means of spreading risk around to try to prevent financial catastrophe in the event of a predictable loss. As a means of managing the risks in health, managed care refers to various means of financing and delivering health care. There are many types of arrangements from PPOs to HMOs. The Health Insurance Association of America (HIAA) (1995) lists four key elements common to all types of managed care. They include "management of both the financing and delivery of health care; institution of cost control techniques; some sharing of financial risk between providers and payers; and management of the utilization of services." (HIAA, 1995, p.33). Managed care arrangements vary along a continuum moving from lesser to greater control of the health care options of the beneficiary. Generally, plans exercising greater control cost less to the enrolled individual while those allowing more enrollee choice of provider and treatment cost more.

As I noted above, managed care is a current set of methods developed within the context of a relatively free market for health care. Historically, those who lack confidence in free markets to support the delivery of quality care at a reasonable cost have proposed NHI. Such proposals have come by various labels but for this article, any proposal that advocates the government become the guarantor of either the costs or the delivery of health care or both will be referred to as NHI. Thus far, proponents of relatively free markets have won the debate over health care financing and delivery. What might be surprising to mental health professionals is that the debate has been going on intermittently throughout this century. Just when it seems inevitable that Congress and the executive branch might agree on a national health care plan, opponents of NHI point to developments in the private sector, such as managed care, to demonstrate that a government take over of health care is not needed.

The Early Development of Health Insurance

A recent history of the payment for health care reveals that it has only been within the last century and a half that an individual could buy a promise of third party reimbursement for health care (HIAA, 1996; Numbers, 1984). The growth and development of health insurance seems to correspond to the fragmentation of close knit communities and families (Eilers, 1963; Faulkner, 1960). As Western societies became more industrialized with increased hazards and potential for injuries, insurance allowed for the pooling of risks to protect families with increasingly loose ties to kinship systems. For instance, since approximately the 13th century, seamen in the Scandinavian and British societies were provided coverage for sickness. By the 1700s, Britain had passed compulsory sickness insurance for seamen and railway workers. Generally, occupations which did not allow for family and community support were covered by these plans.

Accident insurance on the developing British railway system seems to be the forerunner of modern health insurance. The Railway Passenger's Assurance Company of London was chartered in 1848, providing benefits for accidental death or severe injury. In 1850, the Accidental Death Association of London was set up to provide coverage for medical expenses for injuries not resulting in death. In the United States, later that same year, the Franklin Health Assurance Company of Massachusetts was organized to provide accident insurance. By 1864, the Traveler's Insurance Company of Hartford was offering coverage for injury and by 1866, over 60 other insurers were offering health and sickness coverage (Faulkner, 1960).

This early period of coverage was marked by bankruptcies and financial instability in the insurance industry (Hooker, 1956; James, 1947). Health and sickness insurance plans were viewed with great suspicion by insurers (Eilers, 1963). One of today's leaders in group health insurance, The Prudential, dropped its sickness coverage for females and reduced benefits for males during the 1870's (May & Oursler, 1950). The main reason for this early failure seemed to be the inability of the insurer to predict health risk. Many early insurers doubted that sickness could ever be predictable enough to be an insurable risk.

The Role of National Health Insurance (NHI) in Market Reform

Germany was the first European country to legislate national health insurance (NHI) in 1883. Many industrializing nations in Europe followed Germany's lead. In this country, the Socialist party advocated for NHI in 1904. In 1911, Britain established compulsory social insurance. Inspired by the British example, President Wilson's Commission of Industrial Relations in 1916 proposed NHI as one component of improving the labor-management relations (Numbers, 1984; Wasley, 1992). Initially, the American Medical Association (AMA) supported such proposals. Numbers (1984) quotes the *Medical Record*, in 1916 as saying that, "social health insurance is bound to come *sooner* or later..." (p.6). However, by 1920, proposed limitations on payments for medical care reversed physician support to opposition.

In contrast to NHI proposals, many fraternal organizations established health insurance plans for their members. For instance, in 1917, a survey in New York City found over a thousand small health insurance funds associated with fraternal lodge associations (Wasley, 1992). Generally, the AMA opposed lodge practice because the lodges would often take the lowest of several competing bids from physicians to provide all of the health care for a lodge plan. Dues paying lodge members would see the physician contracted by the lodge in a manner similar to the way a preferred provider organization (PPO) operates today. According to Wasley (1992), any physician who contracted with a lodge risked losing membership in their county medical society. A rough analogy in today's environment would be to imagine the American Psychological Association (APA) dismissing from membership psychologists who participate in a managed care panel.

As mining and railroad companies expanded into the frontier, they provided medical care to their workers by hiring doctors to be available on site. Generally, as with lodge practice, organized medicine in the form of the AMA was opposed to the "company doctor." Such arrangements, according to the AMA, eroded physician incomes (Wasley, 1992). Thus the AMA was opposed to both prepaid health care plans and NHI prior to the depression. AMA's opposition, along with the development of the company doctor and the advent of World War I put NHI proposals on hold.

The Depression era brought many calls for national health insurance in this country (Numbers, 1984). When the original Social Security Act was debated in 1934-1935, proponents sought to tie comprehensive health coverage to the Social Security Program (Harris, 1964). President Roosevelt commented during a 1939 address that a "comprehensive health program was required as an essential link in our national defenses against individual and social insecurity." (Harris, 1964, p. 304). A payroll tax was suggested by proponents as the means of financing the expansion of health coverage.

Hard financial times and the prospects of socialized health care spurred the rapid development of alternative systems of payment. In 1929, the forerunner of Blue Cross/Blue Shield plans was developed. A group of 1,500 school teachers arranged for the Baylor University Hospital to provide health care for a monthly pre-payment. The fee was paid even if nobody used the hospital. This arrangement provided coverage for the subscriber and needed income for the hospital. This concept provided a model for the development of the Blue Cross plans which were established in Sacramento in 1932 (Wasley, 1992). Also in 1929, the Ross-Loos Clinic was established in Los Angeles as the first Health Maintenance Organization (HMO). A decade later, the Kaiser-Permanente plan was developed for Kaiser Aluminum construction workers (Dorken, 1983).

Initially, the AMA and insurers were distrustful of these new arrangements (Numbers, 1984). The doctors felt pre-payment organizations interfered with the doctor-patient relationship and reduced incomes. Insurers recalled the tumultuous early experience attempting to predict risk in personal health. However, to help reduce risk to the insurer, a form of managed care was implemented. In the Baylor plan, coverage was restricted to services provided in a hospital setting. Insurers came to believe that "moral hazard" (the insured feigning illness to get benefits) could be managed by requiring a hospital setting since "few would accept hospitalization unless it was necessary" (Hall, 1974, p. 1079).

In 1937, in the midst of proposals for NHI, the Health Service Plan Commission was established to oversee the new Blue Cross plans that were developing across the country. The first Blue Shield plan was formed in 1939. Called the California Physician's Service, the plan covered physician's services outside of the hospital. Modeled after the Blue Cross plan for hospitals, the plan was formed in part to oppose compulsory health insurance legislation in California (Eilers, 1963). The AMA, although wary of insurance plans, endorsed the plan as long as the doctor-patient relationship was not compromised. The AMA feared the advent of socialized medicine more than the concept of competition over fees. With AMA blessing, great expansion of Blue Cross/Blue Shield plans occurred after 1940 (Eilers, 1963).

Congressional advocates of NHI introduced legislation yearly during the mid-1940s which would have created, via payroll tax, a national benefits package consisting of preventive, diagnostic and curative services. The plan would have allowed freedom-of-choice of physician, access to specialists and limited dental and ancillary care. The Truman administration believed this plan would have promoted the improvement in health care and the cost efficiencies of a national plan. Truman's plan called for a payroll tax with enhanced care for the indigent. However, by 1949, the Truman plan had all but died (Harris, 1964). Again, the medical profession opposed the plan due to fears of federal control of medicine. The expansion of private health insurance was cited by opponents of the plan as a means of avoiding a government take over of the health care system (Harris, 1964).

The success of the "Blues," along with emergence from the Depression and the advent of World War II spurred phenomenal growth in the entire health insurance industry (Eilers, 1963; Faulkner, 1960). Eilers (1963) notes that between 1946 and 1956, the total number of persons covered by insurance rose from 42 million to 116 million with 53 million being Blue Cross/Blue Shield subscribers. Commercial insurers were eager to be in the market since Blue Cross/Blue Shield Plans demonstrated that group health risks could be predicted and underwritten profitably. Also prompting premium growth during this era was the wage freeze during World War II. Unions and other employee groups found that bargaining over health benefits allowed an expansion of earnings without raising wages (Baker & Dahl, 1945). These series of events helped tie the possession of health insurance to employment.

The period from the mid 1950s to the mid 1960s saw expansion of certain benefits, such as vision and prescriptions in certain plans (HIAA, 1996). In the 1960s, the expansion of the Great Society saw the federal government become a major force in the provision of health benefits. Social Security, first enacted in 1935, was expanded to include hospital insurance for disabled and elderly (Medicare) and indigent (Medicaid) (HIAA, 1996). Mental health services were expanded due to passage in 1963 of the Community Mental Health Centers Act. This legislation allowed the creation of community based, government supported mental health centers. Some observers felt that the establishment of these programs would blunt the need for NHI to cover the entire population (Harris, 1964).

Despite the development of a federal safety net for the elderly and indigent, continually rising costs prompted a coalition of labor and provider groups to again begin calling for NHI in the late 1960s and early 1970s. Senator Edward Kennedy introduced legislation called the Health Security Plan in 1970 (Wasley, 1992). This plan proposed a free health care system which would replace all private and public health plans with a federally operated system. In reaction, the Nixon administration proposed the expansion of Health Maintenance Organizations (HMOs). The Health Maintenance Organization Act (1973) gave support to the development of HMOs. The Nixon Administration predicted that by 1980, 90% of the population would have an HMO available (Fein, 1986). In 1974, the Employee Retirement Income Security Act (ERISA) was enacted with provisions that exempted certain employee benefits from taxation and regulation (HIAA, 1996). This statute generally is credited with supporting the trend into self-insurance. Self-insurance saves money by exempting businesses from state mandates for certain services, such as mental health. Business owners could write health plans with meager coverage and upper limits on benefits payments. Thus, some of the cost pressures which led to NHI proposals were temporarily eased by limiting benefits.

Beginning with the Kennedy proposal, the decade of the '70s saw a sustained debate over the enactment of NHI. Although the major outcome of this debate was a number of statutes refining the Medicaid and Medicare programs (Fein, 1986; HIAA, 1987), health professionals began positioning for inclusion in the coming system. For instance, psychologists debated the appropriateness of inclusion of mental health benefits (Dorken, 1975; Meltzer, 1975). Kovacs, in 1975, asserted that "within the next two years it is likely that the United States will join most of the countries of Western Europe and adopt comprehensive health care plans for all citizens of the nation." (Kovacs, 1975, p. 1161). Kovacs further expressed only guarded optimism that psychology would be included. Thus, the concern that NHI would

leave psychology out of coverage gave rise to a flurry of legislative lobbying activity often yielding freedom-of-choice legislation mandating third party payment for psychologists (Dorken & Carpenter, 1986).

Despite the sense of inevitability surrounding the enactment of universal coverage, NHI was not enacted. Many factors contributed to this failure, including the nation's preoccupation with the end of the war in Vietnam and Watergate (Wasley, 1992). Also important was the expansion of a market based approach to health care issues—HMOs. While HMOs were not created during this period, they were seized upon by anti-NHI forces as a free market solution.

With the election of President Reagan in 1980, the prospects for NHI dimmed (Wasley, 1992). However, throughout the decade of the 1980s, health care costs accelerated at almost double the rate of inflation (Fein, 1986; HIAA, 1987). Changes in delivery systems continued to accelerate with more employers opting for self-insurance and managed care (Chenoweth, 1988). Due to these cost increases, the debate over NHI took the form of calls for employer mandated health coverage (Cantor, 1990; Swartz, 1990) and expansion of Medicaid benefits to the uninsured population (Clark, 1988; Wagner, 1990).

Often at the center of debate over health care costs was the mental health benefit (Bartlett, 1990; Chenoweth, 1988; Henry, 1990; Warsaw, 1985). The magnitude of cost increases put mental health professionals on the defensive and required efforts at cost containment (Berman, Kisch, DeLeon, Cummings, Binder & Hefele, 1987; Koco, 1988a, 1988b, 1988c; Wiggins, 1988). For instance, some large employers were experiencing increases in mental health costs of 30-60% a year (Duva, 1989; Geisel, 1990). Mental health and substance abuse costs accounted for 15-40% of an employer's total health costs (Koco, 1988a). Costs per employee for mental health and substance abuse benefits averaged $244 in 1989, a 17.9% increase from the previous year (Geisel, 1990).

Employers and insurers initially responded to these rising costs by attempting to avoid state mandates requiring coverage, limiting mental health benefits, decreasing yearly and lifetime caps on benefits, increasing coinsurance (costs paid by the subscriber), and limiting the expansion of mental health provider groups. Providers often responded to these efforts by attempting to demonstrate that mental health care could be provided in a cost-effective manner. Some providers, such as psychologist Nick Cummings, put such information to work via the market place. Established in 1985, American Biodyne (the forerunner of Merit Behavioral Care), sought to demonstrate to business that mental health benefits were not only affordable, but could be expanded while the purchaser could save money. Cummings advocated a treatment model featuring "brief, intermittent therapy throughout the life cycle" (Cummings, 1988, p. 314). He described the Biodyne approach as a way for psychologists to take control of their own destiny without harmful dependence upon business interests (Cummings, 1991).

As most providers are painfully aware, the business community responded favorably to such arguments. Managed care grew respectfully through the last half of the 80s. However, one stimulus for managed care to become nearly universal was the renewed debate over NHI.

Health care was a central issue in the Bush-Clinton campaign of 1991-1992. President Bush generally favored incremental reforms; candidate Clinton favored a comprehensive plan which would provide health security for all citizens. In advance of the election, the *Journal of the American Medical Association* published a spe-

cial issue concerning health care reform (Lundberg, 1991b). Thirteen proposals were featured including NHI plans. In an editorial supporting universal health coverage, Lundberg (1991a) wrote that an "aura of inevitability is upon us. It is no longer acceptable morally, ethically, or economically for so many of our people to be medically uninsured or seriously underinsured." (p. 2567).

With the Clinton victory, the stage was set for the legislative debate over NHI. As most readers will recall, the Clinton proposals were vigorously debated but eventually defeated. Throughout the development of the Clinton Health Security Act, businesses were increasingly turning toward managed care principles to help bring down costs. Opponents of the Clinton reforms asserted that the market place could reform the health care cost and care crises through the implementation of managed care principles (McIlrath, 1993; Meyer, 1993). Indeed, after the defeat of the President's health care reform proposal, an editorial in *Business Insurance,* a major trade publication, gave credit to managed care plans for the smaller than expected increase of health care expenditures in 1993. The editorial writer observed that employers "have junked traditional indemnity plans and redesigned their benefits program to encourage employees to enroll in managed care plans...the health care market is making healthy strides in reforming itself" ("Market-driven...," 1994, p. 8).

Discussion

This historical review yields several observations. Health care insurance is a recent development arising to offer financial and health security. Initially, business owners contracted with insurance companies and individual physicians for health care for their employees. Fraternal organizations added health care coverage as a benefit of association membership. However, the increasing costs of health care prompted calls for government intervention. In this country, such intervention has been incremental and targeted to the elderly, disabled and poor. Opponents of complete government control have generally looked to the developments in the market place to address the problems of health care delivery and financing. Health insurance, Blue Cross hospitalization plans, HMOs, self-insurance and finally the increasing sophistication of managed care systems have been advanced by opponents of NHI as free market solutions to the elevations in health care costs and the uninsured. If not for the emergence and development of these methods, the United States might have followed the industrialized nations into NHI.

Selected Benefits of the Managed Care Revolution

While it may be small consolation to providers that health care is currently managed by business interests rather than governmental interests, an argument can be made that managed care has had at least modest salutary effects. They include expanded mental health coverage, an emphasis on efficient forms of treatment, and restrictions on fraud and abuse by health care providers.

Expanded mental health coverage. Today the battle for mental health advocates is not *should* we cover mental health benefits but *at what level* should they be covered? Under the old indemnity style coverage, insurers were skeptical that mental and emotional disorders were insurable risks. Thus, when mental health cost accelerated throughout the 1980s, many insurance plans either dropped mental health benefits or limited them so much that they provided little subsidy to subscribers (McGuire, 1989).

Today, the nation's policy makers have arrived at a consensus that mental health benefits should be included in any benefits package. Despite loopholes in the most recent legislative efforts, a significant advance toward full parity with medical benefits was achieved in the 104th Congress with the passage of the Mental Health Parity Act (P.L. 104-204, Title VII). Such an outcome seems unlikely if the dominant mode of health care financing was unmanaged fee-for-service.

Emphasize efficient forms of treatment. Most of the financial savings generated by managed care principles have come from refusing to authorize inefficient or elective care. Gone are the days of 30-60 day stays in the psychiatric ward. Briefer solution focused care is favored over years of elective psychoanalysis.

In the early days of American Biodyne, a midwestern state saved thousands of dollars due to the refusal of Biodyne to fund the psychoanalysis of some state employees who had been in 2-3 times per week treatment for 5 years. These employees were given a choice to fund their own analysis or move on to a briefer form of mental health care. These funds were available to help other workers who had new programs available, such as weight management, smoking cessation and stress reduction groups, none of which were funded by the former indemnity insurance plan.

Managed care has allowed for a more efficient use of mental health personnel. For instance, MCOs often contract with master's level counselors and social workers. These professionals competently provide psychotherapy frequently at lower rates than doctoral psychologists (Throckmorton, 1996).

Reduced fraud and abuse by providers. As a consultant on reimbursement issues, I have seen numerous examples of fraud and abuse of the reimbursement system by providers. On one occasion, a provider disclosed that he was getting reimbursed for psychotherapy conducted on his sail boat. The provider said he was billing the insurance company as if the sessions were individual psychotherapy sessions conducted in his office because he didn't know how to code for "sailing psychotherapy." On many occasions, providers have made up a plausible diagnosis for a client even though the client did not meet the criteria. Such diagnoses were then used to establish medical necessity and thus generate insurance reimbursement.

Prior to managed care, such antics were widely justified. For instance, renowned strategic therapist Jay Haley suggested on a 1989 audio training tape that therapists should use a diagnosis to generate insurance payments. He said,

> Well, one of the main purposes of labels is to get insurance. You have to label somebody with some diagnostic category for the insurance company to pay for the therapy; and the problem people have is that the insurance companies have no category of the family so that a family therapist has to pick somebody in the family to have a diagnosis. Sometimes the family is asked for volunteers; who will be the patient according to the insurance company? Usually the mother volunteers for that. The therapist tries to find the least offensive category for the person. A nice category is adjustment reaction, because everybody has an adjustment reaction. (Haley, 1989)

There is little doubt that managed care treatment planning requirements have sharply curtailed such activities.

So what's wrong with managed care?

Individuals who dislike managed care arrangements are quick to point out that managed care companies have incentives to maximize profits. Indeed, many providers are correctly outraged when a MCO refuses to authorize clinically necessary services. What providers often fail to consider is that mistakes and unethical behavior perpetrated by MCOs do not define managed care. No matter what system of health care delivery is implemented, fallible, sinful human beings will make errors of judgment and worse, will deliberately deny care to maximize gain. As I pointed out above, the traditional, fee-for-service insurance system was subject to such abuses. Centralized, governmental systems of care are also subject to fraud. In all systems implemented to date, there are powerful incentives to profit by either providing more care than is needed or by withholding authorization to give care. Although beyond the scope of this article, I believe providers, payers, and policy makers must seriously confront the problems of fraud and unbalanced incentives before any system of health care can truly address the issues of comprehensive care at a cost society is able to pay.

Conclusions

Recently in a speech before a labor group, President Clinton renewed calls for comprehensive national health care (Bedard, 1997). Thus, the nation may be headed for another debate concerning the enactment of NHI. While a look at the current situation suggests that a national health care plan in this country would be modeled along the lines of managed care principles, it is interesting to speculate what the next market based development might be to offset proposals for a government run system. Perhaps supporters of medical savings accounts (MSAs) will convince policy makers that this mechanism will help reduce costs, expand treatment options and restore responsibility for health outcomes to the consumer. If history is "déjà vu" then the "all over again" of the future will likely find some market based reform to compete and ultimately prevail over NHI proposals.

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