



Alternatives to Managed Care

RESOURCE DOCUMENT

Approved by the Joint Reference Committee, January 2004

The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." -- *APA Operations Manual*.

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EXECUTIVE SUMMARY

In response to the changing managed care environment, the APA Committee on Managed Care established a subcommittee to document the changes in managed care and to begin the process of thinking about alternative healthcare financing systems. The Committee undertook writing a resource document for APA members to identify and describe the changes that are occurring in the healthcare sector and to prepare them for changes that may occur so that psychiatry can be proactive in meeting these challenges.

The Subcommittee on Future Alternatives to Managed Care reviewed the development of the system of managed care and its effect on the delivery of psychiatric healthcare, including care for substance use disorders. Managed care is a system put in place to contain healthcare costs, but costs continue to rise, and patient care has been compromised.

A model for analyzing the desirability, feasibility, and quality of any current or future healthcare delivery system and anticipating its effect on the role of psychiatry was developed. This model can help psychiatrists assess the potential impact a given healthcare financing system could have on their patients and practices.

The Committee's model to evaluate healthcare systems is divided into three conceptual categories, which include a series of questions. The Committee began the process of prioritizing the items, which is shown below in a descending level of importance.

A. Clinical Care and Services Redesign

Does the system:

1. Allow for treatments known to be effective?
2. Operationalize its practice guidelines in such a way so as to accommodate rather than ignore the unique needs of some patients who don't fit into standard clinical pathways?
3. Provide for timely access to necessary treatment?
4. Include programs for continuous quality improvement?
5. Appropriately address the need for a continuous healing relationship?
6. Promote continuation of care, which includes necessary social supports?
7. Prioritize safety, including the use of such tools as data feedback to practitioners, privileging above licensure, and practice guidelines?
8. Advocate for treatment in the least restrictive setting?
9. Prioritize care that is patient- and family-centered?

B. Healthcare Financing Reform

Does the system:

1. Put the majority of healthcare premium dollars into treatment?
2. Minimize administrative overhead?
3. Provide parity for mental illness, including substance use disorders?
4. Provide funding commensurate with the level of distress, impaired function, or disability?
5. Provide comprehensive coverage for mental illness, including substance use disorders?
6. Include a mechanism for keeping the plan's deductible within reasonable boundaries?
7. Contribute to research?
8. Include rather than exclude illnesses or treatments?
9. Provide incentives for consumers to actively participate?
10. Provide incentives for practitioners to actively participate?
11. Provide incentives for purchasers to actively participate?
12. Include catastrophic stop-gap insurance coverage?

C. Structural and Systemic Changes

Does the system:

1. Function efficiently when implemented?
2. Reasonably empower its members (consumers) to actively participate in its success?
3. Make it easy for the layman to navigate the system?
4. Provide accessibility across numerous settings (work, school, etc.)?
5. Ensure coverage for those with impaired ability to recognize, appreciate, or accept their need for mental health services, including substance abuse treatment?
6. Use cost control mechanisms that do not undermine the clinical category criteria listed above?

Current modifications and experiments to the healthcare system are discussed and analyzed. Disease management, although not a healthcare finance system per se, is rapidly becoming a major driving force within the healthcare industry. On the immediate horizon of healthcare financing reform are the "consumer-driven" or "consumer-centric" systems, such as defined contribution plans. These are also being tested by corporations to reduce healthcare costs.

Several APA members embarked on developing alternative healthcare systems, which are briefly discussed in the paper. Their proposals are presented in their entirety in the Appendices.

In the document summary the authors note that none of the current systems address the growing number of people who have no healthcare benefits at all. Even without universal coverage, it is possible to compile a better healthcare financing paradigm than what we currently have by combining the best of today's management tools. One such paradigm is presented to demonstrate how the information in this resource document can be used to effectively navigate the business of delivering healthcare.

I. PREFACE

In 2002, in response to the changing managed care environment, the APA Committee on Managed Care established a subcommittee to document the changes in managed care and to begin the process of thinking about alternative healthcare financing systems.

We started by looking at the current healthcare systems of managed care and its traditional management tools for lessons that could be learned (Sections II and III). We then reviewed the APA document "A Vision for the Mental Health System," adopted in April 2003, and the Institute of Medicine's *Principles of Healthcare Services*, published in March 2001. (See Appendix A and Appendix B for complete documents.) Using these two documents and the lessons learned from managed care as our foundation, we developed a model for analyzing any current or future healthcare financing system and anticipating its effect on the role of psychiatry (Section IV). For ease of discussion, the model is divided into three conceptual categories: clinical care and services redesign, healthcare financing reform, and structural or systemic changes.

In Section V, Disease Management, a cost-control and quality-improvement strategy is discussed. This method of supporting the work of physicians and guiding them into treatment pathways is a major focus of planners.

In Section VI, we describe a variety of consumer¹-driven healthcare systems, such as defined contribution plans, that corporations have started

¹Healthcare purchasers: The customer base for businesses that sell healthcare coverage plans, manage benefits, or administer benefits. Also referred to as payers. The term "employer" is sometimes used interchangeably with "purchasers" or "payers," because employers are the major class of purchasers. However, there are some entities that purchase healthcare coverage that are not employers (e.g., individuals, unions, chambers of commerce, professional associations). From *The Managed Health Care Handbook* by Peter R. Kongstvedt, 1996.

testing to reduce costs. Once again, we see that employers are the driving force behind many of the changes in healthcare financing today, but whether these consumer-driven systems will be the future of healthcare remains uncertain.

In Section VII we present three alternative healthcare systems in their early development stages that have been put forward by APA members. The San Diego County Medical Society has proposed one system that advocates for a type of defined contribution plan. Raphael A. Rovere, M.D., developed another alternative system, which is an adaptation of the concepts of health reimbursement arrangements (such as medical savings accounts), universal coverage, and disease management, with emphasis on physician education. The alternative provided by Jonathan L. Weker, M.D., is a type of single-purchaser universal health system. These alternative systems are still in their conceptual stage and are presented in the hope of stimulating further discussion. We recognize that other systems will be added to the discussion as more ideas emerge.

Finally, in the Summary (Section VIII) we consolidate the better management tools from the various systems reviewed to create a potential, realistic, "best practice" plan that could be implemented today.

We are indebted to the Subcommittee on Future Alternatives to Managed Care, which was chaired by Kevin L. Smith, M.D., for its hard work in developing and writing this Resource Document. Working on the Subcommittee with Dr. Smith were Norman A. Clemens, M.D., Anthony M. D'Agostino, M.D., Lawrence B. Kraus, J.D., Lawrence B. Lurie, M.D., Rodrigo Muñoz, M.D., David Nace, M.D., Raphael A. Rovere, M.D., Jonathan L. Weker, M.D., and Marketa M. Wills, M.D.

By proactively evaluating potential future healthcare financing systems and their management tools, the Subcommittee on Future Alternatives to Managed Care hopes to foster a higher quality of patient care, a higher level of professional satisfaction for psychiatrists, and increased funding for the treatment of the mentally ill. The APA's efforts at the federal and state levels and its recent outreach to the business community are both key to influencing the healthcare system of the future. It is our hope that this paper will encourage and lend support to the APA's active participation in the process of determining how mental healthcare will be delivered in the United States.

Lawrence Lurie, M.D.
Chair, Committee on Managed Care
December 2003

II. INTRODUCTION

Managed care has dominated the healthcare system in the United States since the mid-1990s. However, managed care today is not as it was in 1993. According to some, managed care and its strategies are evolving; according to others, managed care is dying. In any case, nearly all agree that managed care and the delivery of healthcare in the United States are changing.

Researchers have reported that the world of managed care is changing (Coddington and Ay-Bass, 2000), and APA members have indicated that their issues with managed care are also changing. For example, calls from psychiatrists to the APA's Managed Care Help Line during the 1990s, especially after managed care was first introduced, were most often about how to get onto managed care panels, what to do when treatment was denied, how to appeal denials, unacceptably binding contracts, and low reimbursement rates. Today, members most often call about confidentiality issues, late payment of claims, and, in a real reversal, how to remove one's name from managed care panels.

Furthermore, the demand for psychiatric care has increased, yet the supply of psychiatrists has not grown to meet the need. Thus a new market dynamic has evolved during the past few years. It seemed the appropriate time, therefore, for the APA's Committee on Managed Care to

document these changes and to explore alternatives to the current managed care systems.

Purchasers of Health Insurance and Economic Realities

Psychiatrists recognize that funds to treat patients are limited and that funding today is even more limited than it was a decade ago. With limited resources for healthcare comes the responsibility of deciding how to access that care. Physicians are faced with a particularly troubling dilemma, because they must treat patients and at the same time be aware of the costs of that treatment.

Today, employers pay for nearly half of all healthcare costs in the United States (Fleming, 2003). This uniquely American arrangement started in 1929, when Dallas schoolteachers were insured to protect them from the high cost of hospital care. Tying health insurance to employment accelerated during World War II, when the defense industry had trouble attracting skilled workers, wages were frozen, and healthcare benefits could be an incentive for hiring. Since the 1970s, when healthcare costs began to escalate, employers have tried various mechanisms to control their costs, including copayments, deductibles, peer review, and prospective payment schemes for hospital reimbursement.

Until recently, care management has been the primary mechanism used by employers (and some public agencies responsible for Medicaid and privatized alternatives to traditional Medicare) to control how clinicians spend the money for which the purchasers of care are accountable. Managed care organizations (MCOs), using utilization review to limit the purchaser's financial risk, were created to act as agents for purchasers of services (Shore, 1998). Managed behavioral health organizations (MBHOs), also known as carve-outs, were then created as agents to manage mental health benefits separately from the rest of medical-surgical care.

With the economy in a weakened state and healthcare costs rising, purchasers are again tinkering with the system. Some recent strategies of large employers include disease management programs and "consumer-driven" healthcare benefit packages (described below). Some employers, of course, have simply reduced healthcare benefits. Furthermore, both the private and the public sectors are struggling to control pharmaceutical costs as an immediate solution to rising healthcare costs and lowered funding.

Strategies to Manage Healthcare Costs

The techniques and strategies used by all purchasers, both public and private, to control costs are in and of themselves neither bad for the mentally ill nor good, if they allow for clinically appropriate, high-quality treatment. In theory, asking physicians to justify that treatment is medically necessary should not pose a problem for physicians or patients, although the term "medically necessary" has been misused in the past by some MCOs to deny benefits to which patients are entitled. Similarly, arbitrarily limiting the kinds and quantity of treatments available to patients has frequently and inappropriately been used by some MCOs to restrict patient access to necessary care. Even the reality of being required to seek preauthorization for treatment, particularly when onerous or complicated, can present barriers to access for those with mental illness and can be extremely burdensome for physicians.

The American Medical Association has produced a number of reports on reforming the healthcare system. One of the most recent reports summarizes the three key elements of the AMA healthcare reform proposal to expand health insurance coverage and choice; these elements are 1) income-related, refundable, advanceable tax credits toward the purchase of health insurance; 2) individual rather than employer ownership and selection of health plan; and 3) promotion of alternative markets through which to purchase coverage (AMA, 2003).

Rather than simply tinker with the current healthcare system, as purchasers are struggling to do at this time, the APA Committee on

Managed Care decided to think outside the box and explore alternative systems. The Subcommittee on Future Alternatives to Managed Care was formed to carry out the exploration, and its first task was to look for lessons to be learned from the current managed care practices.

III. LESSONS LEARNED FROM MANAGED CARE

The initial efforts of MCOs focused on growing their customer base of healthcare purchasers.² To do that, they needed to reduce the cost of healthcare for the purchaser. Hence, the initial business goals of managed care were to reduce cost, grow market share (number of covered lives), and increase profit margins. To accomplish these goals, several strategies were implemented.

Strategies and Results

MCOs initially used the following techniques, which are based on typical business strategies, to accomplish their goals:

- *Limited practitioner networks.* MCOs selected physicians who were part of their panels or networks, who adhered to the plan's philosophy, and who accepted the MCO's fee scale. No longer could any licensed physician be reimbursed for treating any patient. Gatekeepers. Primary care doctors became gatekeepers for the system and were responsible for controlling access to specialty services.
- *Medical necessity authorizations.* To contain costs, MCOs made pretreatment "medical necessity" determinations based on the physician's request for treatment (the outpatient treatment report). As a result, a very significant change in healthcare occurred as the purchaser began to "participate" in the healthcare decision-making process, which had heretofore been considered sacrosanct between doctor and patient.³
- *Negotiated payments,* including practitioner risk sharing. Often physicians in networks would accept a lowered fee so that MCOs would funnel patients to them, or they would share the risk of the pool of covered lives either by accepting payment on a per capita ("capitation") basis or on a percentage withhold basis.
- Gain market leverage by growing plan membership.
- Reduce costs by taking advantage of economies of scale.

MCOs achieved immediate savings and enhanced profitability by implementing these business strategies. In mental health, most of the savings occurred in reducing inpatient days, but the HayGroup found that employers were also reducing mental health funding disproportionately (HayGroup, 1999). The total value of general healthcare benefits was

²See Glossary.

³Insurers have had benefit plans for the past 50 years or so. Benefits have been "managed" by specifying what is covered as well as what is not covered and under what conditions; the phrase "medically necessary" has been used in these plans. What changed in the 1990s was requiring the "medical necessity" determination before service delivery (what the Employee Retirement Income Security Act [ERISA] refers to as "pre-service claim determination") as opposed to following service delivery and claim submission (what ERISA refers to as "post-service claim determination"). Also, before managed care, the physician attested to the necessity of treatment, not the payer or MCO. The determination made before service had a stronger impact on patient and provider healthcare decisions than the previous method of looking up one's benefit plan, getting the service, and then submitting a claim to see if the service already provided would be covered. What also changed, and with particular impact for mental illness, including substance use disorders, was the introduction of criteria for specific levels of care—criteria about which the professions have lacked consensus.

reduced by 10% from 1993 to 1998, but the value of mental health benefits was reduced by 54% during that same time period. This occurred because the dollars saved on inpatient psychiatric care were not reallocated elsewhere in mental health, such as outpatient therapy or intermediate care services. Hence, even though the mental health benefits for many consumers were expanded, the total and relative percentage of dollars for mental health were dramatically reduced.

The Hay Group also found that administrative costs for managed care companies were often reaching well into the 30%–50% range. According to a recent article (Reuters, 2003), a comparison of healthcare costs completed by Harvard University and the Canadian Institute for Health found that 31 cents of every dollar spent on healthcare in the United States pays administrative costs, nearly double the rate in Canada. Researchers who prepared the comparison said that the United States wasted more money on health bureaucracy than it would cost to provide healthcare to the tens of millions of the uninsured. This study found that Americans spend \$752 more per person per year than Canadians in administrative costs.

Between 1999 and 2001, MCOs departed sharply from their previous business strategies in three important ways:

- Offering less restrictive products and product features
- Actively retracting from their often adversarial, friction-ridden contracting relationships with practitioners
- Focusing more clearly on profitability than on growth in market share

However, these new strategies were implemented when the economy was still fairly robust. Today, renewed, rapid medical inflation and a very weakened economy present major challenges for MCOs, and it is not clear what they will have to offer in this extremely challenging financial environment. One thing is certain: The future of managed care will depend, as always in a market economy, upon the purchasers.

Impact of Managed Care on Mental Health Access

Psychiatrists in large numbers have left managed care networks or closed their practices to managed care beneficiaries. Currently, only 54% of APA members are accepting new patients covered by managed care (APIRE, 2003). From the outset, some patients had found it difficult to locate a psychiatrist within their area or their needed specialty, but now that psychiatrists are leaving the networks, the problem of access has been exacerbated to the point where patients may have to telephone 10–12 psychiatrists before finding one who would accept them as a patient, and even then they may wait four to six weeks to be seen.

Can Managed Care Change Enough?

Managed care plans are being forced to change for many reasons. Consumers are becoming more active healthcare participants and are demanding more choice, greater flexibility, and fewer restrictions on access and service delivery. Employers (purchasers) are concerned about the effects of restrictive managed care in sharply reducing timely access to psychiatrists for their employees. Because disharmony between MCOs and practitioners has resulted in network instability,⁴ purchasers and consumers are pushing for stable networks—a push that is giving practitioners important leverage in negotiating with plans. Physicians, including psychiatrists, are pressuring—and getting—MCOs to pay more, to reduce the scope of risk in risk-contracting arrangements, and to reduce

⁴For example, in Orange County, California, St. Joseph's Health System cancelled its contract with PacifiCare in the fall of 2000, affecting nearly a third of the plan's local enrollment. In Seattle, more than 150 specialists cancelled their contracts with Regency Blue Shield in December 1999. The situation prompted several large employers to seek performance guarantees from the plan.

the burdensome authorization process. State and federal regulators are being pressured as well to make changes in how managed care entities can operate. In addition, the courts, including the U.S. Supreme Court, are filled with lawsuits against various managed care practices (Draper et al., 2002).

In spite of these pressures, managed care still presents troubling problems for the mentally ill and the professionals who treat them. Recent traffic on the APA's managed care listserv attests to continuing frustrations psychiatrists experience in dealing with MCOs and MBHOs. Access to psychiatrists and high-quality treatment is still lacking under many of the plans. Burdensome administrative duties are reported frequently to the APA's Managed Care Help Line. Low fees to physicians and others are still another source of aggravation, as well as late payment of claims.

Psychiatrists' Experiences With Managed Care

Throughout the 1990s and into the early 2000s, clinicians questioned whether the mentally ill were receiving high-quality mental healthcare. The list of grievances made by the APA with MCOs has grown long and includes the following:

- Patients were discharged too soon after hospitalization, e.g., hospital days for a seriously depressed or psychotic outpatient could be limited to 2–5 days.
- Definitions of medical necessity were vague, unknown, clinically inappropriate to the point of being absurd, or dangerously restrictive. For example, in some plans, psychiatric patients were not considered suicidal and eligible for inpatient care unless they were suicidal on the day of review.
- Decisions about treatment were made by nonmedical personnel or physicians not trained in the appropriate specialty.
- Treatment for mental illness was often split between psychiatrists (who were frequently given authorizations only for medication management) and nonmedical mental health professionals (who provided psychotherapy), leading to poor coordination and potential gaps in treatment.
- Physicians lost autonomy in the treatment process.
- Psychiatrists experienced increased demands for unpaid administrative paperwork (most prominently seen in "requests for authorizations" and telephone reviews).
- Many psychiatrists on panels were paid at lower rates than they normally received.

Initially, there was no appeal to the MCO's decision. Gradually a system of internal appeals was accepted by MCOs, and ultimately most states enacted a system of external review.

Managed care business strategies and healthcare management techniques, as well as their consequences, have become lessons learned for all of us. These lessons have helped form the basis of our model for evaluating healthcare systems, which we believe will help APA members think proactively about alternatives to managed care for financing our mental health system.

IV. A MODEL FOR EVALUATING HEALTHCARE SYSTEMS

In addition to looking for lessons to be learned from the current system of managed care, the Subcommittee on Future Alternatives to Managed Care also reviewed the APA document "A Vision for the Mental Health System" (see Appendix A) and the Institute of Medicine's Principles of Healthcare Services (see Appendix B). Using these two documents, together with the lessons learned from managed care as a platform, the Subcommittee developed a model for analyzing the desirability, feasibility, and quality of any current or future healthcare delivery system and anticipating its effect on the role of psychiatry. For ease of discussion, the model is divided into three conceptual categories:

- **Clinical care and services redesign**
- **Healthcare financing reform**
- **Structural and systemic changes**

Although it is obvious that the category of clinical care and services redesign plays the most important role in delivering the best care to every recipient and ideally should trump the other two categories, it is imperative to recognize that all three categories are mutually dependent if the healthcare finance system proposed is to thrive. Furthermore, although any given criterion may have applicability within more than one conceptual category, here we have assigned each to the category where we think it would have the most potential for influence on the system or where the system has the most influence over the criterion. We prioritized the items within each category in what we believe is a descending level of importance. The Committee recognizes, however, that there is room for debate with the prioritization.

A. Clinical Care and Services Redesign:

Does the system:

1. Allow for treatments known to be effective?
2. Operationalize its practice guidelines in such a way so as to accommodate rather than ignore the unique needs of some patients who don't fit into standard clinical pathways?
3. Provide for timely access to necessary treatment?
4. Include programs for continuous quality improvement?
5. Appropriately address the need for a continuous healing relationship?
6. Promote continuation of care, which includes necessary social supports?
7. Prioritize safety, including the use of such tools as data feedback to practitioners, privileging above licensure, and practice guidelines?
8. Advocate for treatment in the least restrictive setting?
9. Prioritize care that is patient- and family-centered?

B. Healthcare Financing Reform

Does the system:

1. Put the majority of healthcare premium dollars into treatment?
2. Minimize administrative overhead?
3. Provide parity for mental illness, including substance use disorders?
4. Provide funding commensurate with the level of distress, impaired function, or disability?
5. Provide comprehensive coverage for mental illness, including substance use disorders?
6. Include a mechanism for keeping the plan's deductible within reasonable boundaries?
7. Contribute to research?
8. Include rather than exclude illnesses or treatments?
9. Provide incentives for consumers to actively participate?
10. Provide incentives for practitioners to actively participate?
11. Provide incentives for purchasers to actively participate?
12. Include catastrophic stop-gap insurance coverage?

C. Structural and Systemic Changes

Does the system:

1. Function efficiently when implemented?
2. Reasonably empower its members (consumers) to actively participate in its success?
3. Make it easy for the layman to navigate the system?
4. Provide accessibility across numerous settings (work, school, etc.)?
5. Ensure coverage for those with impaired ability to recognize, appreciate, or accept their need for mental health services, including substance abuse treatment?

6. Use cost control mechanisms that do not undermine the clinical category criteria listed above?

In the rest of this paper, we explore various alternative systems that are currently emerging or may be on the horizon. We use this model to evaluate their potential impact on consumers with mental illness, including substance use disorders, and the practice of psychiatry.

V. DISEASE MANAGEMENT

Before presenting some healthcare system alternatives to managed care, we want to first review disease management as a cost-control and quality improvement strategy. Although it is not a healthcare finance system per se, it is rapidly becoming a major driving force within the healthcare industry deserving of our attention and understanding.

When evaluating healthcare management strategies and healthcare financing systems, it is important to keep in mind that the mere presence or absence of a strategy is not necessarily as critical as the method by which it is employed. There is no better example of this principle than the strategy of disease management.

Disease management is based on two concepts: 1) the scientific principle that evidence-based medicine and other data can provide us with best practice guidelines for treating a particular disease and 2) the basic business principle that standardization leads to efficiency and cost reductions.

Disease management includes all of those practices focused on a particular chronic disease state and can include patient registries, patient education, patient outreach, practitioner education, best practice guidelines, data sharing (e.g., practice profiling and prescription claim information), treatment compliance, coordination of services, and practice guidelines.

Practice guidelines, also called clinical pathways, are sets of recommendations that provide a standardized roadmap for the treatment of a particular disease or diagnosis-related group. The standardization of the treatment roadmap is what allows for efficiencies in treatment of the disease and for realizing the benefits of economies of scale when purchasing the medical supplies and medications required for managing the disease. By removing variability among practitioners, standardization of treatment has been shown to improve disease treatment and treatment outcomes. Furthermore, the standardization of disease treatment simplifies the process of performing analyses of outcomes within and among practitioners, which can enhance the effectiveness of an organization's continuous quality improvement program.

In its worst form, disease management becomes a mandatory clinical pathway that all practitioners are required to adhere to if patients' care is to be covered by their healthcare plan. One simplistic example would be an MCO's disease management pathway for major depressive disorder that requires failure on two formulary SSRIs before the off-formulary drug venlafaxine XR (Effexor XR) may be tried, and the MCO covers hospitalization only if the patient is expressing suicidal ideation with a very specific plan and demonstrable intent.

In its best form, disease management provides for high-quality, cost-efficient care that accommodates the uniqueness of a particular case as long as the clinical judgment behind the treatment is valid and documented. Using the same simplistic example, an insurance plan pays for a patient with major depressive disorder to receive venlafaxine XR as a first-line treatment rather than an SSRI (as mandated by the plan's clinical pathway) because the doctor has documented a family history of two primary relatives with major depression who have failed all other drug regimens but responded very well to venlafaxine XR. In addition, the plan's clinical pathway includes an MCO case manager, who calls the patient daily for the first several days of treatment to provide education about the medication and the disease, answer any questions, and verify the patient's treatment compliance. The MCO clinical pathway recommends hospitalization if the patient has severe distress, severe functional

impairment, and/or grave disability that creates a high dangerousness risk that cannot be safely addressed by a less restrictive treatment alternative.

As more and more evidence-based medical data become available, disease management is expected to become a central focus of every healthcare financing system. This will be especially true for psychiatry, which has often been viewed, albeit erroneously, as one of the most difficult medical specialties in which to quantify treatments and outcomes.

We will discuss and assess this and other major systems and tools by looking at their impact on clinical, financial, and structural aspects of healthcare delivery.

Evaluation of Disease Management

Review of disease management as a healthcare management strategy, based on our model for evaluating healthcare systems, exposes many of its potential positive and negative consequences for patients and psychiatric practice, some of which are noted here:

- Disease management can be used to provide data feedback to healthcare organizations and physicians, which in turn can promote safety, standardization, and efficiency.
- If implemented in a way that does not accommodate the unique needs of patients who do not fit into standard clinical pathways, disease management can be potentially harmful.
- Because disease management standardizes treatment for a given disease, there is less allowance for all treatments known to be effective, except where individual circumstances can justify a diversion from the clinical pathway.
- Criteria for selection of a disease management pathway must not rest on a DSM five-axis diagnostic assessment alone, since there are other variables such as patient preference, personality characteristics, motivation for particular treatment options, failure of past treatments, family history of response to particular treatments, socioeconomic variables, and support systems that affect treatment selection.
- Disease management can promote timely access to necessary treatment, because the entire treatment process from start to finish is standardized. However, it can also become an impediment to access if it is applied rigidly to everyone in all circumstances.
- Treatment in the least restrictive setting and the inclusion of necessary social supports must be integral parts of the clinical pathway design. Disease management must allow for involuntary treatment and restrictive settings when individual circumstances warrant them.
- By virtue of the standardization of treatment inherent in the DM process, disease management can enhance continuous quality improvement programs. Standardization allows a practitioner's treatment and treatment outcomes for a given patient to be readily compared with the same practitioner's outcomes for other patients or for a practitioner's overall outcomes to be compared with those of other practitioners.
- Since treatment is standardized, fewer dollars are needed, theoretically, to administer the system, because only outliers need to be reviewed. Hence, more of the healthcare premium dollars can go into treatment. However, the research and work required to develop the disease management pathways may consume substantial funds.
- Combining disease management with consumer and practitioner incentives to embrace this tool could strengthen its ability to achieve desirable effects on the healthcare industry.
- Disease management is a very efficient tool once implemented and can be used across many settings, depending on how extensively the clinical pathway is designed.
- Active participation of consumers in the success of disease management is dependent upon the design of the pathway.

- Disease management itself is neutral with respect to those with impaired ability to recognize, appreciate, or accept their need for mental health services, including substance abuse treatment. The system deploying disease management must actively address this issue.
- Usually disease management can make it easy for the layman to navigate a system, because the care pathway is standardized. The opposite would be true, however, if the system deploying disease management is not able to accommodate the unique needs of some patients who don't fit into standard clinical pathways.
- When used appropriately, disease management can improve quality and contain cost without alienating consumers or practitioners, who should gradually grow to embrace the concept if it is not misused to cut cost at the expense of quality.

VI. "CONSUMER-DRIVEN" SYSTEMS

On the immediate horizon of healthcare financing reform are the "consumer-driven" or "consumer-centric" systems, two superficially attractive words that camouflage the fact that the consumer gets to pay more for them (Healthcare Buyer, 2002). Because most of these constructs are relatively new, the terms used to define them have not been solidified. They all have in common two key elements:

- **Increased consumer involvement**
- **Increased consumer cost sharing**

The recent and rapid movement toward more consumer involvement in health insurance decisions has come about for a variety of reasons, including the sustained backlash against managed care from patients and clinicians, the failure of managed care to control the rising cost of healthcare for purchasers or to deliver the promised access to timely care, growing recognition of the benefits to be derived from consumers being more responsible and involved in their healthcare decisions, increased availability of healthcare information on the Internet, aging of the baby-boomer population, and increased direct-to-consumer marketing by pharmaceutical firms.

The theory behind consumer-driven healthcare is that if employees have more control over the funds set aside for their healthcare they will be more responsible about what is spent on that care. The rule of thumb is that people respond to out-of-pocket payments by reducing their use of healthcare; this is not necessarily medically desirable or ultimately economical when it discourages early intervention or access to preventive services. Consumer participation can range from something as limited as employees choosing from a number of insurance policies made available by an employer to something as open as giving employees a health voucher to use as they see fit.

Employer costs for healthcare benefits account for 27% of national health expenditures (Nichols, 2002). As a result, employers looking for new ways to control their costs currently play a major role in shaping the future direction of healthcare financing. According to a recent survey conducted by Hewitt Associates (Hewitt, 2003), a human resources consulting firm, 70% of employers plan to increase employee cost sharing in 2003, and 68% intend to increase the amount employees pay for coverage of their families. Hewitt Associates reported that after the IRS issued new guidance on Health Reimbursement Arrangements (described below) in June 2002, 46% of the employers they surveyed said they were interested in these plans and 72% said they were interested in offering employee-customized benefits designed to decrease employer costs.

Below we describe five types of consumer-centric systems: Defined Contribution Plans, Health Reimbursement Arrangements, Employer Health Plan Choice Systems, Tiered Practitioner Networks, and Voucher Plans. Each description is then followed by an assessment based on our model for evaluating healthcare systems.

Defined Contribution Plans

Defined contribution plans can represent a movement away from traditional managed care plans, depending on how they are packaged. Before 2003, these plans were not offered on a wide scale. However, initial reports indicate that consumers are choosing to migrate to these plans now that they are being offered. In fact, defined contribution plans are the most prominent type of consumer-centric healthcare option currently available and have seen significant penetration into the healthcare market in 2003. They therefore represent the most immediate concern for mental healthcare practitioners and consumers to address.

With defined contribution plans, employers contribute a set (or defined) amount of money to the employee's healthcare account. Employees then add their own pre-tax money at whatever level they choose and use the sum total of the healthcare money pool to select a plan. Although defined contribution plans represent a wide variety of approaches to providing healthcare benefits, all are intended to give beneficiaries incentive to control the costs of the healthcare they receive.

Here's one example of a health benefit package structured with a defined contribution plan: The employer contributes a flat \$4,000 per employee per year. Employees may contribute whatever pre-tax dollar amount they choose on a monthly payroll deduction basis. The employer has arranged for discounted group rates for two popular health maintenance organizations (HMOs), one preferred practitioner organization (PPO), and one point of service plan (POS). The monthly premiums and deductibles are least expensive for the HMOs and most expensive for the POS. Employees may choose one of these plans or can use the funds to purchase an individual policy elsewhere (what some employers refer to as "opting out").

Evaluation of Defined Contribution Plans

Use of our model to evaluate defined contribution plans reveals that virtually every criterion for a high-quality system could be overlooked. The plan chosen by a consumer will adequately address key criteria only if the consumer chooses to contribute enough pre-tax dollars to select a better plan. Additionally, the following consequences are possible:

- Defined contribution plans are built on concepts intended to create financial incentives for patients to actively participate in cost control rather than health maintenance.
- Defined contribution plans do not inherently offer incentives for practitioners. The absence of the hassles of managed care, combined with the cost burden placed on the patient, might not be adequate to entice practitioners to actively participate in the success of a plan.
- Since defined contribution plans essentially create a cap on the cost of healthcare benefits to the purchaser (i.e., the employer), irrespective of the actual cost of the benefits to the consumer, purchasers may become disengaged from the consequences of the system no matter how negative.
- Since consumers take a much more active role in healthcare decisions and pay more first-dollar costs, they may be financially driven to choose less expensive and therefore less comprehensive coverage, which essentially expands the pool of underinsured consumers.
- If employers fail to recognize the importance of mental health and substance abuse treatment, the inclusion of these benefits may be left solely to the employee, who may choose to deny any possible future need for these services in exchange for lower-cost healthcare coverage.
- Employers have a vested interest in ensuring that their employees receive high-quality healthcare, with full access to effective treatment of mental disorders, including substance use disorders. Defined contribution plans preclude employers from taking a role in providing healthcare.

- Mentally ill persons with impaired ability to recognize, appreciate, or accept their need for mental health services, including substance abuse treatment, may choose to deny the need for coverage irrespective of the cost.
- First-dollar costs and deductibles may become so expensive as to dissuade consumers from seeking healthcare early on, when the problem can best be addressed.

Health Reimbursement Arrangements

Health reimbursement arrangements (HRAs) are rapidly becoming a central focus of the consumer-driven health benefit movement. Personal care accounts, health spending accounts, flexible spending accounts, and medical savings accounts are variations on the theme, depending on whether the employee can also contribute funds to the account and what kind of restrictions there are on use of the funds. As has always been customary, the employer and the employee generally share the cost of the insurance premiums for whatever insurance policies are included in their healthcare benefit package.

A typical employer's healthcare benefit offering comprises some kind of basic health insurance, usually with a high deductible, some form of catastrophic stop-gap insurance, and the HRA. With some of these HRA accounts, the employee can also contribute pre-tax dollars that can be used to pay for qualified healthcare expenses. Employees may use the HRA funds to help pay the high deductible, after which the basic health insurance plan kicks in up to its specified limits, or they may use the funds to purchase medical services not covered by the basic health insurance. The catastrophic stop-gap insurance provides coverage for those unusual circumstances where the cost of a member's healthcare exceeds the limits of the basic insurance. In other words, catastrophic stop-gap coverage is an insurance umbrella for the basic insurance policy—a double-tiered design that keeps the cost of the basic policy even lower than it otherwise would be solely because of its high deductible.

There are many different ways in which HRAs can be offered or packaged to meet various needs of the employer and/or employee. Some employers offer to cover certain health expenses fully before the HRA has to be used. For instance, employers may cover preventive care outside the deductible because they do not want their workers to be skipping necessary care to save money. In another variety, HRAs can be combined with some form of managed care, with incentives given for in-network care. HRAs can be "notional," which means the employer retains ownership of the account and, when the employee leaves, the money stays with the employer. Alternatively, they can be "funded," which means the employees would continue to have access to the money to pay for future health expenses after they leave a job.

Consumer selection of HRAs has been catapulted quickly to very high penetration levels in 2003, following a June 26, 2002, IRS Notice and Revenue ruling on the tax treatment of HRAs allowing the residual, employer-contributed funds in an HRA to roll over tax-free into the next year, as long as the funds were paid out only for qualified health expenses. Future IRS updates on whether employee contributions to an HRA can also roll over tax-free will even further influence consumer selection of these plans. Obviously, funds that are rolled over into the next year may allow employees who are not big consumers to have all premiums and deductibles covered in future years.

Here's one example of a health benefit package structured with an HRA: The annual premium for basic health insurance for the employee and his family is \$4,800. The employer pays \$3,800 and the employee pays \$1,000. The deductible for the basic insurance is \$2,500, and its coverage is capped at \$25,000 per year. A catastrophic stop-gap insurance policy is included in the health benefit package by the employer at no charge to the employee. It costs the employer about \$300 per year and has a \$25,000 deductible, which includes all healthcare costs covered by the basic policy. The employer also funds an HRA of \$1,000 per year for each employee, and the employee may choose to contribute pre-tax

dollars to the HRA as well. The HRA funds may be used to pay the basic policy deductible, and since the HRA is funded rather than notional, the HRA dollars are portable to a new employer, should the employee make a job change. However, based on the current IRS rulings, although the employer contributions to the HRA can roll over tax-free from year to year, any residual employee contributions would be taxed as income plus a 15% penalty.

Evaluation of HRAs

Like defined contribution plans, HRAs are vulnerable to not meeting every criterion in our model for evaluating healthcare systems if the employer or consumer is unwilling or unable to cover the cost. However, with HRAs the converse is also true—both employers and employees can choose to pay for inclusion of coverage for those model criteria they deem important without relying on an insurance company to offer the desired coverage as part of a menu of plans. For example, employers may choose to pay for preventive care and an employee assistance program outside of any plan or plan deductible, because they don't want their workers to choose saving money over maintaining their health and mental health and hence their productive work capacity. Similarly, employers may choose to include an MBHO in the HRA to ensure that the mental health of their workforce and its productivity level are maintained as best as possible for the lowest price. Additional potential consequences to consider are the following:

- If the employer chooses to use an MBHO as a constant fixture in its HRA health benefit package, the MBHO may use the same administrative tools as have been used in the managed care era, including precertifications.
- If the HRA is notional rather than funded, consumers could potentially be at risk for compromising their continuous healing relationship with a practitioner when they change employers.
- The first-dollar and deductible costs of the HRA benefit package could be so high as to dissuade consumers from seeking care early on when it can be most beneficial.
- The basic insurance plan included in the HRA package may not offer a continuum of care with the necessary social supports.
- If the benefit package designed by the employer includes a basic insurance policy, catastrophic coverage stop-gap, and an HRA, are there gaps in coverage caused by the building block design of the package?
- In designing the HRA package, did the employer and employee address parity for mental health, including substance abuse?
- HRA benefit packages do not necessarily include incentives for clinicians to actively participate in their success.
- In order for purchasers (employers) and consumers (employees, patients) to be willing to pay dollars for comprehensive mental health coverage, they must recognize and accept the fact that mental health is critical to maintain productivity, reduce lost workdays, and minimize employee turnover and disability. Even if they accept these concepts, will consumers be willing to pay for them, since they primarily benefit the employer?
- The HRA-based benefit package must be designed to function efficiently and to be easily negotiated by the consumer.

Employer Health Plan Choice System

As with defined contribution plans, employer health plan choice systems (also called out-of-pocket choice systems) offer several types of plans from which the employee chooses. For example, the employer may offer one or more HMO plans, one or more PPO plans, and one or more POS plans. The premiums differ by choice, with HMOs having the lowest and POS having the highest. Large employers, like the federal government in its Federal Employee Health Insurance Plan, have used this system for years. What distinguishes employer health plan choice systems from defined

contribution plans is the employer's contribution to the cost. With defined contribution plans, the employer's contribution to the cost is fixed, or defined. With health plan choice systems, the employer contribution varies in one of two ways—they either fully subsidize the cost difference or they pay an across-the-board percentage of whatever the employee-chosen plan costs.

Evaluation of the Employer Health Plan Choice System

Since employer health plan choice systems are basically like defined contribution plans, their review using our model for evaluating healthcare systems raises the same potential concerns and consequences as with defined contribution plans. The singular, noteworthy exception is that the employer's cost-share is not defined or fixed, so the employer does share more of the cost of a better plan. This could promote better coverage by reducing the consumer's financial burden for choosing a better plan, or it could dissuade better coverage, because the employer may not want to incur the extra costs.

Tiered Practitioner Networks

Tiered practitioner networks (TPNs) are inspired by the tiered copays used by pharmacy benefit managers and represent an evolution of the practice of paying one level of benefits for in-network practitioners and another for out-of-network practitioners.

Under this system, employees pay different copays for different tiers of practitioners. Physicians, hospitals, and other practitioners are tiered according to the level of discount offered. Presumably, practitioners who offer the biggest discounts are in the lowest copay tier.

Evaluation of TPNs

For consumers, TPNs provide an incentive to pay more for potentially better care. However, they may also mislead consumers into believing that they must pay more to get access to better care, or even good enough care. To create incentives for practitioners to perform better, TPNs must connect tier assignment to outcomes and other practitioner assessment information. If the network tiers are performance-based, then purchasers, consumers, and practitioners may realize incentives to make the system work.

Our model for evaluating healthcare systems highlights the following issues:

- Consumers who no longer can afford to pay a higher cost for a higher tiered practitioner may risk losing their continuous healing relationship.
- If the TPN is performance-based, it has a good opportunity to prioritize safety using such tools as data feedback to practitioners, privileging above licensure, and practice guidelines.
- TPNs risk consuming large percentages of healthcare premium dollars on tier administration and adjudication.
- Provision of parity for mental illness, including substance use disorders; funding commensurate with the level of distress, functional impairment, or disability; and comprehensive coverage for mental illness, including substance use disorders, are not necessarily part of TPNs. However, if the TPN incorporates evidenced-based medicine into its performance-based tiering, then it will most likely find that providing parity and comprehensive coverage for mental illness, including substance use disorders, is vital to its success.
- TPNs may or may not include catastrophic stop-gap insurance coverage.
- TPNs are neutral with respect to ensuring coverage for those with impaired ability to recognize, appreciate, or accept their need for mental health services, including substance abuse treatment.

- TPNs can be relatively easy for consumers to navigate, but only if they have ready access to the information used to tier the practitioners and the cost difference between each tier.

Voucher Plans

Under voucher plans, employers give their workers a voucher to purchase their own health insurance directly from an insurer. Employees who choose a plan that costs more than the amount of the voucher make up the difference. For employees who choose a plan that costs less than the voucher would be refunded the difference in after-tax dollars. According to the Employee Benefit Research Institute (Nichols, 2002), as of June 2002, no employers were using this system. There are many problems with vouchers, the most obvious of which is that it's more expensive to buy insurance as an individual than as a group.

Evaluation of Voucher Plans

The evaluation of voucher plans cannot be completed until we know what healthcare benefits consumers purchase using the voucher. Most likely, the larger the cash value of the voucher, the better the coverage would be.

VII. CONCEPTUAL SYSTEMS FROM APA MEMBERS

As part of working toward the goal of thinking proactively about future alternatives to managed care, members of the Committee accepted the challenge to place themselves outside of any known box and create a new paradigm for financing healthcare. What follows are brief overviews of the first three of what we hope will become many creative alternatives to managed care. Additional and more detailed information about each system can be found in Appendix C, Appendix D, and Appendix E. Since these systems are still in their conceptual phase, their assessment according to our model for evaluating healthcare systems will be left to the individual reader in hopes that it will encourage refinements and perhaps additional, creative submissions from other members of the professional psychiatric community.

San Diego County Medical Society System⁶

The San Diego County Medical Society has assimilated several principles it believes are key to a successful alternative to the managed care system of healthcare delivery. Conceptually, their system is most similar to a consumer-driven healthcare system. According to this system, a successful alternative to the managed care system must:

1. Connect consumers to the cost of their day-to-day healthcare by reducing or eliminating most first-dollar insurance coverage.
2. Empower consumers to discover the cost of healthcare services in advance of consumption.
3. Reduce or eliminate capitation as a form of practitioner reimbursement.
4. Provide for full tax deductibility of healthcare expenses for all, including expanding the availability of HRAs.
5. Encourage employer-defined contributions as opposed to employer-defined benefits.
6. Promote private ownership of all health insurance policies.
7. Support mandatory, community-rated catastrophic health insurance.
8. Require adequate funding mechanisms for the provision of government-mandated services.

⁵Presented by Rodrigo Muñoz, M.D., to the Future Alternatives to Managed Care Subcommittee, September 2002. See *Appendix C* for full proposal.

Rational Approach to the Healthcare System

The Rational Approach to the Healthcare System is a proposed healthcare system alternative crafted by Raphael A. Rovere, M.D.⁶ Conceptually, it is a merger of defined contribution plans, a national or universal coverage system, and quality outcomes measures. It can also be viewed as a way to implement the San Diego Medical Society System within a national healthcare system.

Funds for healthcare would flow from some type of HRA funded by employers and employees for the employed; by the individual and the government for the marginally employed; and entirely by the government for the unemployed, disabled, and retired. The funds in the HRA would be entirely controlled by the HRA members.

A not-for-profit corporate entity, known as a triage-depository organization (TDO), would hold and invest HRA funds, completely controlled by the covered life members, who are the owners of the HRA. The HRA would connect members to physician practitioners; purchase community-rated catastrophic insurance; negotiate with hospitals directly for inpatient care; and negotiate with a physician educational research certification organization (see below) for services. The medical coverage provided by the TDO for its members would be standard, uniform, and broad. The medical coverage would be supplemented completely by catastrophic insurance so that there would be no gap in coverage.

The federal and state governments would be able to enroll Medicare and Medicaid members in the TDO by depositing funds directly into the TDO.

Another not-for-profit corporate entity, known as a physician education research certification organization (PERCO), would consist of physicians and staff and would be open for membership to all physicians for a fee. It would have three major functions: 1) physician postgraduate training, education, and formulation of best practice guidelines; 2) collection and analysis of treatment, treatment outcome, and utilization review data for the purpose of improving the quality of care; and 3) voluntary annual certification of member physicians. Certification would be based on criteria provided by the AMA and medical specialty organizations, to include but not be limited to effectiveness (reduction of rates of morbidity and mortality), efficiency (use of practice guidelines, best practices, and cost control), and patient satisfaction. Individual physician members of the PERCO would be allowed to participate in other healthcare delivery entities, such as PPOs and physician hospital organizations (PHOs). These entities would be free to negotiate a reimbursement rate with the TDO on their own, should they wish to do so.

A separate not-for-profit physician negotiation organization (PNO) would negotiate the basic value of the reimbursement formula with the TDO through "Black Box," "Messenger," and other techniques to conform to antitrust rules and regulations.

Consumer-Rationed Universal Coverage⁷

Jonathan L. Weker, M.D., proposes reconsideration of a universal coverage system that includes consumer control over healthcare expenditures and rationing. Conceptually, this is a merger of consumer-driven healthcare concepts and universal coverage.

Dr. Weker points out that there is a limit to the financial resources that can be devoted for healthcare. Since the American public has found neither the will nor the way to assume responsibility for determining how much healthcare it wants and how much healthcare it is willing to pay for, rationing decisions have been consigned to various special interests.

⁶"Rational Approach to Healthcare" presented to the Committee on Managed Care by Ralph Rovere on January 2003. See *Appendix D* for full proposal.

⁷"Rational Rationing of Healthcare" by Jonathan L. Weker, presented to the Committee on Managed Care on January 17, 2003. See *Appendix E* for full proposal.

When health insurance companies exclude or limit coverage for certain for Medicaid but too little money to buy commercial insurance, when conditions or treatments, when a segment of the population is unable to obtain health coverage because they earn too much money to be eligible doctors decline to accept people into their practices who cannot afford to pay, or when businesses limit their employees to restrictive healthcare plans or don't offer health insurance benefits, the result is healthcare rationing.

If the public would assume responsibility for these decisions, then the situation could change. In order to accomplish this, a number of very significant steps would need to be taken.

The accidental marriage between access to healthcare and place of employment would be dissolved. Health insurance, which employers "give" to their employees, is part of their compensation. However, with employer-based health insurance, the employer decides for its employees how their healthcare compensation is spent.

In the proposed system, the people to whom healthcare access is provided would own the healthcare system. Covered lives would assume the responsibility of deciding how much healthcare they want to purchase and then pay for it directly. This line of thought has, in the past, mistakenly led many people to equate popularly owned systems of healthcare access with the current, government-sponsored health insurance, namely, Medicare and Medicaid.

The public would ration its own healthcare through newly formed healthcare institutions, Boards of Health. Like Board of Education members, proposed Board of Health members would be popularly elected but operate separate from federal, state, or local governments. They would be responsible for determining what healthcare services will and will not be provided at common expense. Just as Board of Education members don't micromanage teachers in their teaching, neither would Board of Health members get in the way of the doctor-patient relationship. They would determine society's healthcare budget and be empowered to collect the public funds to pay for it. As with education, if individuals want something different from, or in addition to, what the publicly funded healthcare systems provide, they can pay for it out of their own pockets. If the public doesn't like the rationing decisions or the expense determinations that the Board of Health has made, the public could vote those members out at the next election.

VIII. Summary

Managed care practices drastically altered the treatment of people suffering from mental illness, including substance use disorders. Access to treatment has been limited and drastically restricted. Patients have often had to call numerous psychiatrists to find one who will see them on their insurance plan and then may have had to wait for many weeks to get an appointment. Because an MCO care manager ruled it "medically unnecessary," patients have been denied care to which they felt entitled. They have been forced to leave hospitals when still severely distressed, severely functionally impaired, or gravely disabled because these criteria were not part of the MCO's hospital treatment criteria. And now, as new tools for controlling costs emerge, patients could potentially still be challenged with similar misfortunes and yet have to pay more out of their own pockets for it.

Managed care emerged and evolved in just a few years, bringing with it a whole new way of providing healthcare and practicing psychiatry. It may or may not change enough to survive into the future, as new and more novel approaches for controlling healthcare costs emerge. As tools for managing and systems for financing healthcare continue to emerge, evolve, and become extinct, it has become clear that the management of healthcare, in some form or fashion, is here to stay.

Our model for evaluating healthcare systems can help psychiatrists assess the potential impact a given healthcare financing system could have on their patients and practices. Perhaps the model can even help us proactively to create a better system for the future.

What none of the systems in this resource document has attempted to address, except for the rational approach to the healthcare system proposed by Dr. Rovere and the consumer-rationed universal coverage system proposed by Dr. Weker, is the growing number of people who have no healthcare benefits at all, either because their employer does not offer any or because they cannot afford the cost themselves. Since healthcare institutions that receive federal funding must provide care without regard for source of payment or ability to pay, this large pool of healthcare cost has a direct impact on the financial security of these healthcare institutions as well as the cost of healthcare for all of us. Unfortunately, universal coverage, irrespective of the deployment plan used, will require major changes in political policy, social system structure, and public acceptance before it will have a chance of becoming a reality.

Even without universal coverage, it is possible to compile a better healthcare financing paradigm than what we currently have by combining the best of today's management tools, as determined by the criteria contained in the model for evaluating healthcare systems. One such better paradigm is presented here to help demonstrate how the information in this resource guide can be used to effectively navigate the business of healthcare.

Alternative Paradigm

The employer (for example, the Federal Employee Health Insurance Plan) establishes a health benefits package that requires full parity for mental illness, including substance use disorders. The package includes 100% coverage with no deductible for preventive healthcare services, such as vaccines, mammograms, prostate screenings, colon cancer screenings, and stress management training. A basic health insurance plan with a standard deductible of \$2,500 and a \$25,000 per year cap is provided. The employer pays 80% of the modest monthly premium, and the employee pays 20%. The basic insurance includes, as required, parity for mental illness, including substance use disorders. It also incorporates a performance-based, tiered practitioner payment structure, which allows the consumer to choose to see better, more expensive practitioners by paying a higher deductible. The only healthcare services that require pre-certification from the insurance companies are inpatient hospital care and the highest-cost outpatient diagnostic studies. Case managers are available on request from the consumer and/or practitioner, who can provide patient advocacy services, including education, treatment compliance monitoring, and assistance in navigating the healthcare continuum and insurance benefits.

The employer also provides a funded HRA at the rate of \$1,000 per employee per year, and the employee can contribute pre-tax dollars to the HRA at whatever level he or she chooses. The employee is allowed to spend these dollars on any acceptable medical care. Employee dollars are spent first in order to minimize the tax impact on the employee at the end of the year and to increase the dollar amount that can be rolled over into subsequent years. In addition, the employer fully funds a "life services" program for consumers that may also be tapped by practitioners to help provide social support services in appropriate cases.

Included in the basic and catastrophic insurance plans are disease management guidelines. These guidelines provide clinical pathways for practitioners to follow, but do allow for individual variability that is clinically justified in the documentation. Practitioners receive quarterly intra- and extra-practitioner continuous quality improvement feedback reports based on their use of the disease management guidelines and their clinical outcomes. These reports are summarized annually and the results used to rate practitioners for establishing tier assignments for the next year.

Using our model for evaluating healthcare systems, we find that this system:

- Appropriately addresses the need for a continuous healing relationship.
- Has the capacity to prioritize safety using data feedback to practitioners, privileging above licensure, and practice guidelines.

- Implements its practice guidelines in such a way as to accommodate rather than ignore the unique needs of some patients who don't fit into standard clinical pathways.
- Allows for treatments known to be effective, if the consumer chooses to pay for that treatment using their HRA funds.
- Minimizes the time consumers might have to wait for treatment authorizations.
- Is neutral regarding treatment in the least restrictive setting.
- Promotes a continuum of care that includes necessary social support.
- Includes programs for continuous quality improvement and ties practitioner incentives directly to them.
- Focuses a very large majority of healthcare premium dollars on treatment and treatment outcomes, although administering the performance-based tiered network could consume significant dollars.
- Provides parity for mental illness, including substance use disorders, and therefore better provides funding commensurate with the level of disability.
- Provides comprehensive coverage for mental illness, including substance use disorders.
- Includes a mechanism for keeping the plan's deductible within reasonable boundaries by adding an HRA account and, including catastrophic coverage stop-gap.
- Does not contribute to research, except by promoting performance-based assessments and DM guidelines.
- Minimizes the administrative overhead of precertifications.
- Does not exclude illnesses or treatments.
- Provides incentives for members to actively participate.
- Provides incentives for clinicians to actively participate.
- Provides incentives for practitioners to actively participate.
- Includes catastrophic stop-gap insurance coverage.
- May or may not function efficiently when implemented.
- May or may not provide accessibility across numerous settings (work, school, etc.).
- Reasonably empowers consumers to actively participate in its success and provides access to case manager advocates, who can assist them in navigating their benefit choices and treatment options.
- By requiring parity, it ensures coverage for those with impaired ability to recognize, appreciate, or accept their need for mental health services, including substance abuse treatment.

APPENDIX A: A VISION FOR THE MENTAL HEALTH SYSTEM

On April 3, 2003, amid the deepening funding crisis in state and local mental health services, the APA unveiled a far-reaching blueprint to guide the rebuilding of our crumbling mental health system—"A Vision for the Mental Health System". A blue-ribbon task force of psychiatrists from the public and private sectors prepared the report.

APA President Paul S. Appelbaum, M.D., a member of the task force, has emphasized that the report "lays out a set of principles to rebuild and reform our mental health system, and provide a system of care for our most vulnerable citizens."

Task Force Chair Steven S. Sharfstein, M.D., noted that the APA's mental health blueprint was prepared in anticipation of the Final Report of President George W. Bush's New Freedom Commission on Mental Health. Dr. Sharfstein expressed the hope that the Commission's report "will include many of the twelve critical principles for our mental health system."

The twelve principles outlined in "A Vision for the Mental Health System" are:

1. Every American with psychiatric symptoms has the right to a comprehensive evaluation and accurate diagnosis that leads to an appropriate, individualized plan of treatment.
2. Mental healthcare should be patient and family centered, community based, culturally sensitive, and easily accessible without discriminatory administrative or financial barriers or obstacles.
3. Mental healthcare should be readily available for patients of all ages, with particular attention to the specialized needs of children, adolescents, and the elderly. Unmet needs of ethnic and racial minorities require urgent attention.
4. Access to mental healthcare should be provided across numerous settings, including the workplace, schools, and correctional facilities. An emphasis should also be placed on the early recognition and treatment of mental illness.
5. Patients deserve to be treated with dignity and respect. When they are clinically able they are entitled to choose their physician or community-based agency and to make decisions regarding their care. When they are incapable of doing so, they should receive the treatment they need and when able, they should choose future care.
6. Patients deserve to receive care in the least restrictive setting possible that encourages maximum independent access to a full continuum of clinical services, including emergency/crisis, acute inpatient, outpatient, intermediate level, and long-term residential programs.
7. Since mental illness and substance abuse occur together so frequently, mental healthcare should be fully integrated with the treatment of substance abuse disorders and with primary care and other general medical services.
8. Support must expand for research into the etiology and prevention of mental illness and into the ongoing development of safe and effective treatment interventions.
9. Efforts must be intensified to combat and overcome the stigma historically associated with mental illness through enhanced public understanding and awareness.
10. Health benefits, access to effective services, and utilization management must be the same for people with mental illness as for other medical illnesses, preferably funded by integrated financing systems. Although states are the ultimate locus of responsibility for the public safety net, the federal government and the private sector employers must also support an increased investment in the mental health of Americans.
11. Funding for care should be commensurate with the level of disability caused by a psychiatric illness. Disability occurs both in the severely and persistently mentally ill and in patients with other unforeseen psychiatric conditions who suffer despite having previously been productive and functional.
12. More resources should be devoted to treatment and to training an adequate supply of psychiatrists, especially child psychiatrists, to meet the current and future needs of the population.

⁸Members of the task force were Steven S. Sharfstein, M.D., Chair; Paul S. Appelbaum, M.D., President of APA; Norman A. Clemens, M.D.; Anita S. Everette, M.D.; David Fassler, M.D.; Susan L. Padrino, M.D.; Roger Peele, M.D.; Darrel A. Regier, M.D.; and Michelle B. Riba, M.D.

⁹The final report is available at <www.mentalhealthcommission.gov/>.

APPENDIX B: INSTITUTE OF MEDICINE PRINCIPLES OF HEALTHCARE SERVICES

The Institute of Medicine was established by the National Academy of Sciences in 1970 so that public policy health issues could be explored by experts in the field. The stated mission of the Institute of Medicine is "to advance and disseminate scientific knowledge to improve human health." Its goal is to provide "objective, timely, authoritative information and advice concerning health and science policy to the government, the corporate sector, the professions, and the public."¹⁰

In its March 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine outlined several basic principles for high-quality healthcare services in the future. According to this report, the healthcare system should have seven specific principles for improvement, based around the need that high-quality care be

1. Based on a continuous healing relationship
2. Safe—avoiding injuries to patients from care that is intended to help them
3. Effective—providing services based on scientific knowledge to all who can benefit and refraining from providing services to those not likely to benefit
4. Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions
5. Timely—reducing wait and sometimes harmful delays for both those who receive and those who give care
6. Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy
7. Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

Although these aims would seem to be obvious requirements for a high-quality healthcare system, the mental health system in the United States has seen these very basic principles wither in the face of the much more prominent forces of market economy and corporate profit margins.

¹⁰See the Institute of Medicine's Web site: <www.iom.edu/about.asp>.

APPENDIX C: SAN DIEGO COUNTY MEDICAL SOCIETY SYSTEM: Medicine at a Crossroads—A Prescription for Change

Background

Quality healthcare should be uniformly accessible and affordable, and all patients should have the security of knowing that they are protected from financial catastrophe as a consequence of major illness or injury.

In San Diego County, healthcare coverage is neither uniformly accessible nor affordable. In fact, approximately 25% of the county's citizens lack health insurance coverage of any kind, and cost is the number-one barrier to obtaining coverage. Many physicians believe there has been a very serious decline in access to healthcare services.

One of the objectives of the "Code Blue" rally in October 2001 was to develop public awareness of the precarious condition of the healthcare delivery system in San Diego.

The San Diego County Medical Society believes that severe underfunding of the institutions and professions that actually provide front-line care is the root cause of the problems at hand. Physician groups flirt with fiscal insolvency, while many other groups have already failed. San Diego, arguably one of the most attractive places in the nation to live, is unable to offer sufficient wages to attract enough nurses to adequately staff what is now a very reduced number of acute care beds. Hospital systems are closing their smaller community hospitals in order to concentrate assets and to protect the solvency of their core facilities. The County trauma system is grossly underfunded, with virtually every participating hospital system losing money. The very fabric of San Diego's healthcare delivery is unraveling just as the baby-boomers approach their years of maximum healthcare utilization.

We must act now to change the way we finance healthcare before it is too late! Minor adjustments will not correct for the problems at hand. In the opinion of the San Diego County Medical Society council, the situation requires bold intervention and a totally new approach.

Provided herein are eight proposals for change and a brief executive summary of the history and rationale supporting these proposals. The Medical Society intends to take the lead in assembling a coalition that will implement these changes. Our membership must be the driving force behind this effort.

History of Present Illness

Before and immediately following World War II, most health insurance was high-deductible coverage that protected people against the consequences of extraordinary expenses (catastrophic coverage). Individuals paid their own day-to-day expenses out of pocket (personal funds), and doctors often charged whatever was most appropriate, including such things as chickens or services in kind. The doctor-patient relationship encompassed both the patient's economic status and the patient's healthcare needs. The cost of this type of coverage was affordable.

Businesses began to offer health insurance to their employees as an incentive to stay with the company (the birth of the third-party purchaser). Given the affordability of healthcare at the time, employers gradually began to offer insurance coverage that paid more and more of an employee's total healthcare costs, including day-to-day expenses. Since 1960, inflation-adjusted per capita spending from personal funds, as a percentage of total spending, has decreased by about 67%. While an effective tool for employee retention, disconnecting consumers from the cost of the services they use has had very severe unintended consequences.

Premiums began to increase immediately, since insurance now needed to cover both the costs of catastrophic illness and the day-to-day expenses of millions of generally healthy people. Employees, no longer connected to the costs, consumed more, as there was little financial consequence to using more advanced or expensive services. Practitioners of healthcare services felt free to charge more for their services. Healthcare prices and consumption rose precipitously, causing the

government ultimately to step in to protect the elderly from the resulting healthcare inflation. This further aggravated the situation by making the government the third-party purchaser of choice for virtually all seniors (Medicare) and worsened the problem by disconnecting the largest per capita consumers of care from the majority of their costs.

The Rand Health Insurance Experiment, funded by the U.S. Department of Health and Human Services and reported in 1988, demonstrated beyond any doubt that low deductible insurance that covers first-dollar expenses (day-to-day care) increased outpatient expenditures by as much as 67% and inpatient spending by nearly 30%. Up to that point it had been erroneously theorized that the increased utilization associated with first-dollar coverage was the result of sicker people choosing more comprehensive coverage.

Those paying the bills (employers and public agencies) demanded that the rise in insurance premiums be brought under control. The cost controls inherent to consumers purchasing services with their own funds no longer existed in a system of third-party purchasers. Something had to be done to "administratively" replace the missing cost controls. The "gatekeeper" concept and stringent "utilization review" processes were created to restrict access to the more costly forms of care. Unfortunately, these measures had only limited success, primarily because it was difficult for both physicians and patients to justify limiting patient access to care simply because insurance companies wanted to reduce their medical service losses.

Having failed to adequately restrain the rise in healthcare costs with gatekeeping and utilization review, the insurance industry adopted a new concept for paying practitioners, capitation. Taking advantage of a longstanding rift between primary care practitioners and specialists, insurers drove a wedge between them by offering the primary care physicians the promise of greater income if they would agree to accept fixed prepayments per patient (capitation). Greater income was to be generated by eliminating wasteful use of expensive services and specialty care. Capitation had another attractive benefit for insurers. It virtually eliminated insurer financial risk by passing on the cost of providing care to the doctors and hospitals. At the rates initially offered, capitation was well received and some savings were initially achieved.

Unfortunately, only large medical groups could afford to accept capitation, as individual physicians could not absorb the cost of even one medical disaster. Patients could no longer be self-directing, as medical groups needed every month's capitation payment to offset the cost of an acute injury or illnesses when it finally occurred. Insurers, having captured complete control of a large number of capitated lives, began to progressively reduce capitation rates to well below actuarially sound levels. Medical groups, which had now become dependent on these plans, were obliged to accept financially unsound contracts, as rejecting them would result in the immediate loss of all income and bankrupt all but the very strongest of groups.

Present Day Conditions

By its nature, capitation presents an inherent conflict of interest, since the doctors directing patient care ultimately pay for the services rendered. The potential for abuse increases as the actuarial soundness of the capitation rates decrease.

A more insidious consequence of capitation is the gradual loss of access to more advanced services. It is nearly impossible to justify the cost of cutting-edge technology in a system that barely covers present-day expenses. This becomes even more problematic when underfunded medical groups are unable to subcapitate services unavailable within the group. For hospitals, having surplus capacity clearly works against the bottom line, as it can only result in utilization in excess of capitation payments. As per capita revenue streams decrease, so have the number of hospital beds.

Since the advent of managed care, total, inflation-adjusted per capita healthcare expenditures have increased by about 50%. Few, if any,

believe that managed care has increased access to services. Thus, under capitated managed care, more dollars are being spent than ever before, but consumers have less access to care: leading to the conclusion that the cost of services has actually risen.

From an insurer's standpoint, capitated prepaid first-dollar coverage is a dream come true. Not only are premiums nearly twice as high as conventional catastrophic coverage, but insurers have also managed to retain a similar percentage of the total premium as profit, as if they were still assuming the same degree of financial risk!

It was hoped that first-dollar coverage would encourage utilization of preventive healthcare services, which would then reduce the future incidence of major illness and create a healthcare dividend to offset the cost of preventive care. Unfortunately, the ratio of catastrophic expenditures to first-dollar expenditures has remained remarkably stable over the years and provides little evidence of a significant healthcare dividend.

As previously discussed, coverage for first-dollar expenditures significantly increases the cost of insurance products. Currently, most policies include significant first-dollar coverage, and premium analysis has shown that first-dollar coverage is about 67% more expensive than high deductible products (medical savings account qualifying insurance). Unfortunately, the vast majority of the working uninsured are not legally eligible for medical savings accounts.

The number-one reason given by individuals for not obtaining health insurance and for employers to decline to offer health insurance coverage to their employees is cost. In an attempt to reduce financial barriers to accessing preventive care, we have significantly increased the cost of available insurance products, and have thereby driven nearly one-fourth of our citizens out of the insurance pool all together! The uninsured, no longer participating in the insurance pool, now cost the healthcare system billions of dollars each year in unfunded federal and state mandated acute care services.

First-dollar coverage fosters excess utilization and is, by its nature, much more expensive than true insurance against extraordinary expenses. The public has become addicted to the concept of virtually free healthcare. In the public's mind, health insurance no longer means protection against extraordinary expenses but protection against virtually all expenses. Imagine how much auto insurance would cost if it covered every expense, including new tires, gasoline, windshield wipers, etc., in addition to the major expenses of accidents?

Finally, employer-sponsored first-dollar insurance coverage has spawned a perverse system, based on capitation, that operates on the principle of profiting by denying access to healthcare services.

Overview of Proposals

The proposals herein are not intended to address healthcare for the indigent. This is the province of welfare and the responsibility of government and charity organizations. However, government-sponsored programs could equally benefit from these reforms.

In the United States there are about 187 million insured persons under the age of 65. We believe that it is most rational to design a system of healthcare financing around the needs of the many. The needs of the exceptions should be addressed separately. Our proposals are interdependent and must be considered as a whole, as alteration or omission of one proposal may significantly affect the effectiveness of another. This is the agenda for the discussion that needs to occur now.

1. Reduce or eliminate capitation as a form of practitioner reimbursement.

In practice, capitation has actually increased the cost of services and decreased access to care. It is the driving force behind a dangerous trend of progressive dismemberment of the healthcare infrastructure, just as the baby-boomers approach the age of maximum healthcare utilization. The Council believes patients and the community are far better served when

payments are made for care rendered, not profit from care withheld.

2. Reconnect consumers to the cost of their day-to-day healthcare (reduce or eliminate most first-dollar insurance coverage).

The unintended consequences of first-dollar coverage have erased any tangible benefit of increased access for those lucky enough to still have insurance. In contrast, people who are responsible for purchasing their own day-to-day care and who are protected against financial ruin (catastrophic coverage) will shop for more affordable services and, by doing so, will drive down the real cost of services. High-deductible coverage is significantly less expensive, and more of the uninsured can afford to participate in the insurance pool, thus significantly reducing the amount of unfunded acute care.

The sickest 10% of consumers spend about 76% of total healthcare dollars, primarily within acute care facilities. First-dollar coverage has not changed that reality. The healthiest 90% of the insured population under the age of sixty-five spends about \$500 per year (average less than \$42/month) on health and dental care. While an affordable number per person, it represents a total expenditure of about 93.5 billion dollars in excess insurance premiums, not, including insurance industry profit and overhead. Paying 93.5 billion dollars for day-to-day care means there is that much less money available for acute care needs.

Finally, when patients pay for a significant portion of their care, they will rightfully demand to choose their own physician and the type of care they desire.

3. Empower consumers to discover the cost of healthcare services in advance of consumption.

Once consumers are reconnected to the cost of their day-to-day care, they must also be empowered to shop more effectively for these services. This means that fee information must be made readily available to consumers in advance of consumption. Once a significant number of patients are reconnected to the cost of their healthcare, they will demand information on how to access more affordable high-quality care. Web-based information systems will give consumers real-time access to this information. Organized medicine must fight to enable consumers' to access fee and high-quality information in an understandable format.

4. Provide for full tax deductibility of healthcare expenses for all (including expanding the availability of medical savings accounts).

The general health of its citizenry is a greater good for the nation as a whole. Encouraging consumers to access necessary care by allowing them to deduct qualified medical expenses and catastrophic health insurance premiums from their tax burden is appropriate and necessary. In addition, enabling consumers to save money in a tax-free environment for future healthcare needs (medical savings accounts) significantly reduces the risk of incurring health expenses that exceed one's ability to pay. A gradual transition from employer tax benefits to individual tax benefits will drive the system toward the individual responsibility we support.

5. Encourage employer-defined contributions as opposed to employer-defined benefits.

Consumers, not employers, must choose the type of coverage they desire. Employers have a business interest in their employees' health. Employer contributions toward a wide array of healthcare coverage encourage employees to take

responsibility and to choose to protect themselves against illness and disability that drives down productivity.

6. Promote private ownership of all health insurance policies.

Individuals and families own their insurance policies will choose the type of plan that suits their needs and can change jobs without risking a loss of healthcare coverage.

7. Support mandatory, community-rated catastrophic health insurance.

Like auto liability insurance, mandatory participation in the insurance pool is appropriate and necessary for the benefit of society as a whole. A healthy workforce drives a healthy economy. Community ratings based on age and geographic location enable every individual to obtain protection from financial ruin as a consequence of a major illness or injury. Community rating alone, without a requirement to obtain insurance, could drive up the cost of insurance. A combination of mandated individual coverage and community rating spreads financial risk across the entire population and thus reduces the cost of insurance for those who most need the coverage.

8. Require adequate funding mechanisms for the provision of government-mandated services.

No matter how comprehensive the changes we recommend, some patients will slip through the cracks and appear at hospitals, physician offices, or other healthcare treatment facilities without adequate funds to pay for their care. Legislative mandates to provide care must be accompanied by reasonable methods of reimbursing for the care delivered. It is unconscionable for any government agency to mandate the provision of uncompensated care.

The San Diego County Medical Society believes these proposals to be both reasonable and necessary. The situation demands immediate attention. We solicit your comments.

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APPENDIX D: RATIONAL APPROACH TO THE HEALTHCARE SYSTEM

Origin of Funds

Employed—health saving accounts (HSA), medical saving accounts (MSA), funded by the employer by a defined benefit and completely controlled by the employee.

Marginally employed—HSA funded by a “health grant” from state and federal government, amount income dependent.

Unemployed and retired without health benefit—“health grant,” amount dependent on “personal wealth”

Triage Depository Organization

The triage depository organization (TDO) is a not-for-profit corporate entity that holds and invests HSA funds, completely controlled by “owners” of the HSA. The TDO connects owners to physician practitioners; purchases community-rated catastrophic insurance for owners; negotiates with hospitals directly for inpatient care; negotiates with the physician educational research certification organization (PERCO) (described below) for services. The TDO has two levels of organization, local and national. Such organization allows for interactions at the community level such as referral to appropriate physicians from a list of certified physicians obtained from the PERCO; reimbursement of physicians according to the services rendered and the negotiated reimbursement formula; and accumulation of utilization review data. The national organization permits functions of a broader scope that could best be accomplished by a central office, such as investment of funds.

The TDO has three subsections. The first manages and invests the HSA funds. The second collects and processes utilization review data, which is made accessible to the PERCO. The third interacts with hospitals and other practitioner entities. The medical coverage provided by the TDO for its members is a standard, uniform, broad, nondiscriminatory coverage with parity for mental health services. The medical coverage is supplemented completely by the catastrophic insurance so that there is no gap in the coverage.

Physician Education Research Certification Organization (PERCO)

PERCO is a not-for-profit corporate entity, consisting of physicians and staff, which is open for membership to all physicians for a fee. It has three major functions. The first is to focus on physician postgraduate training education by making available from the medical literature state-of-the-art information on algorithms, best practices, and decision trees on diagnosis and treatment and their implementation. The second is to collect treatment data and treatment outcome data with the physician members’ help and to combine these data with utilization review data from the TDO. The PERCO then analyzes all the data collected for the purpose of improving the quality of care. The third function is to assess the member physicians as certified or not certified. The assessment is voluntary on the part of the physicians.

A reimbursement formula is assigned on the basis of physicians’ categories. There is a yearly reassessment of physicians as long as the physicians are assessed positively. A negative assessment requires the physician to wait six months to request a reassessment. The six-month wait continues after each negative assessment until there is improvement. As part of the voluntary assessment, the physician consents to the release of information to the TDO. The PERCO provides the TDO with information on the ongoing certification of physicians for a reasonable fee.

Certification is based on criteria provided by the AMA and medical specialty organizations, to include but not be limited to effectiveness (reduction of rates of morbidity and mortality), efficiency, (use of practice

guidelines, best practices, and cost control), and patient satisfaction. The major emphasis is on an educational process for physicians, whereby they have timely access to clinical breakthroughs that are evidence-based. These findings are incorporated into “best practice” formats that are sufficiently flexible to allow for clinically appropriate treatment for all patients. Subtle and reasonable pressure is maintained by the certification process on physicians to apply the “best practice” protocols in their clinical practices. Because of antitrust considerations, the relationship between the PERCO and professional medical associations such as the AMA and the specialty societies must be at arm’s length. The societies’ involvement is limited to providing pro bono consultation in establishing certification criteria.

Physician Negotiation Organization (PNO)

The PNO is a not-for-profit and voluntary organization that negotiates the basic value of the reimbursement formula with the TDO through a “Black Box,” “Messenger,” or other technique to conform with antitrust rules and regulations. To further comply with antitrust issues the individual member will probably need the option of accepting the negotiated value of the reimbursement or negotiate a personal value. Furthermore, the individual physician member of the PERCO is allowed to maintain his or her existing and future participation in any entity that is organized vertically, such as a physician practitioner organization (PPO) or physician hospital organization (PHO). These entities are free to negotiate a reimbursement rate with the TDO on their own if they wish to do so.

Medicare and Medicaid Inclusion

The federal and state government may enroll the members of Medicare and Medicaid programs in the TDO by depositing the funds directly into the TDO. This would give the federal and state government a means of controlling costs.

Issues to Consider

How does this system differ from the managed care system?

- It places total control of the healthcare dollar in the hands of patients, whose representatives control the TDO.
- It allows an opportunity for the unused health savings accounts to grow by investing and compounding, and eventually a portion of these funds will be returned to the owners.
- It provides the patient with essential information necessary for making informed choices on healthcare and for taking responsibility for these choices.
- It is reasonable to assume that a significant amount of the 50% of the healthcare dollar that is used by the managed care industry for profit, administrative costs, and marketing will be saved and used more productively within the healthcare system.
- The monetary incentive for physicians is placed on clinical competence, quality of care, and patient satisfaction instead of limitation of care that is the result of capitation and other procedures used by the managed care industry.
- The focus of reduction of variation is on quality of care, competence, and patient satisfaction rather than on capitation and other processes that limit care. This shift in focus is more likely to elicit better cooperation from physicians. Since physicians are responsible for the use of approximately 70% of the medical resources, their greater cooperation will result in increased cost savings. This shift also fulfills the first principle of achieving high quality in healthcare, which is having efficient and effective goals. Cost containment remains an important and central goal in this system. It is achieved in an enhanced fashion by a variety of measures that distinguish this system from the managed care industry system. By the consistent use of algorithms and best

practices, a reduction in variation is achieved, which is the second principle in obtaining high quality in a system. A reduction in variation is also one of the most important processes in cost containment. Such reduction in variation is implemented more effectively in this system, primarily by the educational effort and secondarily by the periodic review of physicians. Constant pressure is maintained both for high quality and cost containment. In summary, the shift in the focus of reduction in variation to quality goals and the more effective use of practice guidelines, best practices, and algorithms will improve the quality of care and lead to significant cost reduction as well.

- Since the PERCO is a physician-controlled organization, it will require less bureaucratic procedures than a managed care organization.

What about physicians' resistance to being rated?

Rating of physicians is essential in order to provide an effective means of connecting monetary compensation to the desirable goals of competency and high quality in the healthcare system. In addition, it will assist patients in making a judicious choice with regard to a physician. The periodic assessment provides the stimulus for physicians to maintain their ongoing competence, which is essential for a functional healthcare system. Since some sort of assessment is the wave of the future, it makes sense to ensure that this assessment is based on criteria that are fair, valid, effective, and hopefully acceptable to physicians. In this way the medical profession will stay ahead of the curve.

Will the use of best practices, algorithms, and guidelines foster "cook book medicine"?

The use of these procedures will not restrict physicians unduly to the point where they will not have access to alternative choices that best fit the needs of certain patients. The rationale for the use of best practices, etc., is to help the physician arrive at the best alternative for the majority of patients in a timely fashion. This is accomplished by bringing state-of-the-art clinical knowledge to bear on the clinical setting. It will not prevent physicians from using an alternative diagnostic or treatment approach that best suits the occasional patient. Physicians need to document the exception and their rationale for the alternative choice; their decision will be accepted if it conforms with the facts of the case. The system employed will make allowances for exceptions to the use of best practices, etc., in documented cases.

APPENDIX E: CONSUMER-RATIONED UNIVERSAL COVERAGE

Do we devote as much of our financial resources to healthcare as we would like?

On the face of it, this might seem like an outrageous question. From all quarters we are being told that healthcare cost increases are fast reaching crisis proportions. Health insurance premiums are rising by as much as 30% this year. Spurned by these cost increases, healthcare is heading toward the top of the election year political agenda. More editorials have been penned on this topic than on perhaps any other in 2003.

None of these factors should be permitted to obscure the real answer to the question: We don't know. Our system of paying for healthcare isn't structured to permit the public to determine how much of our wealth we would like to devote to our health. And until our healthcare financing is restructured to allow the public to make this determination, the healthcare financing crisis will continue.

This problem has evolved, in my opinion, because few if any of the current decision-makers, be they insurance executives, elected officials, business leaders, medical experts, or bureaucrats, seem willing to state that the fundamental question facing us is, How are we to ration healthcare? Rationing is a dirty word in the healthcare financing world, but the truth of the matter is that of course we ration healthcare in our society. We seek more healthcare than we make available; hence, we ration it. We always have. And because we refuse to acknowledge this fact, we ration healthcare irrationally. When health insurance companies, responding to actuarial input, decide to exclude or limit coverage for certain conditions or treatments, that's healthcare rationing. When a segment of the population is unable to obtain health coverage because they make too much money to be eligible for Medicaid but too little money to buy commercial insurance, that's healthcare rationing. When doctors decline to accept people into their practices who can't afford to pay, that's healthcare rationing. When businesses limit their employees to restrictive healthcare plans or don't offer health insurance benefits, that's healthcare rationing.

Put succinctly, because we, the public, have found neither the will nor the way to assume responsibility for determining how much healthcare we want and how much healthcare we are willing to pay for, rationing decisions have been consigned to various special interests. Only if we insist on assuming these responsibilities will the situation change. To accomplish this, however, we must take a number of very significant steps.

First, we must dissolve the accidental marriage between access to healthcare and place of employment. This arrangement has been around for so long that we assume it's a given in the equation, but why should it be? Many of us have automobile insurance, but we don't look to our employers to provide it for us. We have homeowner's or renter's insurance, but we don't expect our employers to make that available either. Why should we think it natural to get our health insurance through our jobs? This arrangement became commonplace during World War II, when wage controls were imposed as a wartime measure. However, we often seem to forget that the health insurance our employers "give" us is part of our compensation. What job-based healthcare insurance amounts to is your boss spending your money on your health—with his or her interests at heart! We have been molycoddled into believing that healthcare is a gift bestowed upon us by the rich and powerful in our society. It doesn't have to be this way.

A healthcare system needs to be owned by the people to whom it provides access to healthcare. Those people need to appropriate the privilege of deciding how much healthcare they want to purchase, and they need to appropriate the responsibility of paying for it directly. This line of thought mistakenly leads many people to equate popularly owned systems of healthcare access with the current forms of government-sponsored health insurance, namely, Medicare and Medicaid. The problem with those systems is that the people who design and manage them are insulated by layers of bureaucracy from the people who use them. If the users of

healthcare don't like the system that the designers have designed, they need to be able to fire them; if they don't like the way the system is being managed, they need to be able to fire the managers.

We need to develop institutions through which the public can ration its healthcare. At first glance, this sounds cumbersome. To my knowledge, only once has something like this been attempted in the United States, when Oregon tried to rank-order the treatment priority of hundreds of medical conditions through a series of public meetings a number of years ago. It didn't work, in part because the constantly evolving nature of medical knowledge and remedies makes it impossible to codify rationing decisions. What is needed is a living, breathing, evolving public institution that can adapt to these changes. This doesn't have to be as complicated as it sounds; in fact, a perfectly serviceable system already exists. The public oversees its public education system through elected Boards of Education. Why not establish Boards of Health to function in a parallel fashion? Like Board of Education members, Board of Health members would be popularly elected yet operate separate from federal, state, or local governments. They would be responsible for determining the healthcare "curriculum," i.e., what healthcare services will and won't be provided at common expense. Just as Board of Education members don't micromanage teachers in their teaching, neither would Board of Health members get in the way of the doctor-patient relationship. They would determine society's healthcare budget and be empowered to collect the public funds to pay for it. As with education, if individuals want something different from, or in addition to, what the publicly funded healthcare systems provide, they can pay for it out of their own pockets. And if we the public don't like the rationing decisions or the expense determinations that the Board of Health makes, we can vote those members out and vote in different people at the next election.

One of the Scandinavian countries made the decision a number of years ago that premature infants below a certain birth weight would not be provided with the extraordinary measures that they needed to survive. This was not because that country wasn't capable of mustering the know-how to accomplish this, much as we do in this country. Rather, the people of that country decided that it was too great a financial and social burden for them to shoulder. As it now stands, we are incapable of making such decisions in this country because we lack the mechanism by which to discern the wishes of the people who have to live with these healthcare access decisions and to pay for them. Advances in healthcare technology are going to accelerate the emergence of such dilemmas. Whatever we come up with, we need to accept the fact that the rules of healthcare need to adhere to the rules of health: Bad things happen. Life is unfair. You can't have it all.

APPENDIX F:

THE COMBINED COMPREHENSIVE HEALTH CARE MODEL

The Combined Comprehensive Health Care Model (CCHCM) presents an outline of a citizen-patient owned and directed health care system that has as its primary objective the achievement and maintenance of quality health care services, with a secondary focus on effectively and reasonably containing costs within parameters established by the system's citizen-patient owners.

Principal Features: The principal features of the CCHCM are:

- Universal coverage of all citizen-patient members of a health care system
- Comprehensive, seamless coverage of all spheres of health care
- Adaptability of the model to either a voluntarily-achieved single payer system or to entities in a multi-system marketplace
- Complete control over the health care benefits and services by the citizen-patient members
- Triage of insured toward qualified practitioners and effective services
- Independent adjudication of health coverage disputes and ethical conflicts
- Achievement and maintenance of high quality care through ongoing collection and dissemination of data, and through the fostering of data based research
- Provision for ongoing, post-graduate education of medical practitioners
- Returning of unused portion of premiums to the citizen-patients
- Participation of private practitioners and institutional providers
- Integration into a synergistic system of improved existing components and new components of the health care system

Introduction: This model is presented with the understanding that its structure and organization, as well as the focus and content of the health benefits, will be modified to accommodate the specific financial and political climates of different localities. The authors anticipate that the model will continue to evolve after it has been implemented in such a way as to maintain and enhance its applicability and viability. The CCHCM grew out of the authors' contributions to the resource document produced by the American Psychiatric Association's Subcommittee on the Alternatives to Managed Care. In formulating the CCHCM, the authors have attempted to integrate the best features of all the models outlined in that resource document into a synthesis that will find wide acceptance and application while maintaining flexibility and responsiveness to local needs. In the opinion of the authors, the successful implementation of this model requires a strategy that has been outlined in a related Action Paper to be presented at the November 2003 meeting of the APA Assembly.

THE MODEL

Summary of structure, governance and operations: The heart of the CCHCM is a Triage-Depository Organization (TDO) whose purposes are, first, to determine and arrange for provision of the scope of health care services; and second, to determine and arrange for collection and investment of the funds that will pay for those services. The TDO's operations will be the responsibility of a Board of Directors whose members are directly elected by the citizen-patient members of the health system. Candidates for Board Directorships will be elected based upon their platforms with respect to the scope of health care services that the system will fund and to the size of the system-wide budget. Implicit in the TDO's function is an understanding that the funding of some health care services will be viewed as the communal responsibility of the health care system while the remainder will be viewed as the individual's responsibility; and that the dynamically-shifting determination of the boundary line

between communal and individual funding responsibility will be entrusted to the elected representatives of the system's citizen-patient owners.

The Triage-Depository-Organization (TDO)

The TDO is a not-for-profit corporate entity comprising all of the citizen-patient "owners" of the health care system. This organization holds and invests the funds collected by the system. It purchases community-rated catastrophic insurance on behalf of the system. The TDO connects citizen-patients to physicians and other health care practitioners from a list of certified physicians obtained from the physician education research certification organization (PERCO; described below). (Alternatively, citizen-patients can select their own practitioners but if the practitioner is non-certified the allocated fee will be lower than for a certified practitioner.) The TDO is entrusted with negotiating with providers of health care services on behalf of its members. These negotiations would take different forms with different entities: the TDO negotiates directly with hospitals and clinics for inpatient, rehabilitation or other institutionally-provided care; it negotiates with the physician negotiating organizations (PNO), described below) for services by group or individual outpatient clinicians. Given the "market clout" of the system's total membership, the TDO might be able to achieve cost savings with respect to pharmaceuticals and other medical supplies by negotiating directly with manufacturers or wholesalers.

The TDO hires a professional administrative staff and consulting professionals with medical and/or financial expertise. These administrators and consultants will serve at the pleasure of the Board of Directors; their relationship with the Board of Directors would parallel that between a school system's superintendent (and professional staff) and a Board of Education. As with the Directors themselves, the health system's administrators and consultants will be remunerated by salary or contracted fee; contingency profiting on the basis of increased or reduced health care expenditures would be prohibited.

The TDO's administrative-consultative staff would be organized into subsections corresponding to the TDO's various functions. One subsection manages and invests the monies collected by the health system. A second administers the health "benefit," i.e., by processing claims and issuing payments for that range of health care services that the Board has determined will be communally funded by the health system. A third subsection collects and processes health services utilization data, which would be made available to the PERCO. A fourth subsection is responsible for negotiating with institutional health care providers, pharmaceutical and medical supply vendors, and the PNO.

The health access mission of the health system, as carried out by the TDO on behalf of its citizen-patients, is based on the fundamental principle that the health "benefit" is to be standard, uniform, broad and non-discriminatory with respect to age, race, gender, social economic status, and nature of illness. No one area of medical suffering (e.g., psychiatric illness) would be uniformly curtailed or neglected. The health benefit offered by the TDO is supplemented by catastrophic insurance so that there is no gap in medical coverage. There is to be an ongoing and concerted effort, in close collaboration with the PERCO, to modify the focus and content of the health care benefit in order to improve it. The purpose will be to embody the principles of the President's New Freedom Commission on Mental Health and the Institute of Medicine's Principles of Health Care Service, as well as to implement the APA's Vision for the Mental Health System. The introduction of these recommendations must be made within the context of a fiscally reasonable plan and with respect for the preferences of the citizen-patient owners, who are to be provided with the information to make reasonable and informed choices.

Several aspects of providing adequate health care require coordination between local health care systems on a national level. This consideration includes such functions as provision of health care services to citizen-patients outside their local area, resource sharing between locales, coordination of financial management for optimizing investment opportunities and purchasing of reinsurance, and establishment of minimal

national standards for TDO operation and scope of health care provision. As such, one might envision the creation of a national association of TDO's with representation proportional to the number of citizen-patients in each subsidiary health care system.

The Committee for Determination of Ethical Issues is a special committee of the TDO which is charged with the responsibility of deciding a variety of ethical issues that the health system might encounter in the course of its operations. Of particular significance, it would adjudicate disputes raised by citizen-patients as to whether the funding of a particular health care service is a communal or individual responsibility. Members of the committee would be directly elected by the citizen-patient owners of the health care system; as such, they would be completely independent of the health system's Board of Directors and the professional administrative/consultative staff. Its decisions would obviate the need for external, commercial managed care entities.

Physician Education Research Certification Organization (PERCO)

The PERCO is a not-for-profit corporate entity consisting of physicians/ professionals and staff which is open for membership to all physicians (and professionals of recognized allied health professions) for a fee. It has three major functions. The first is to focus on physician post-training education by imparting state-of-the-art information from the medical literature in the form of algorithms, best practices, and diagnostic and treatment decision trees (and to encourage their implementation). The second function is to collect treatment and outcome data from physicians and to combine this data with the utilization review data from the TDO in order to provide direct feedback to physicians concerning their individual treatment practices with respect to the practices of the community. Physicians would consent to the release of information to the TDO.

The third function of the PERCO will be to establish and implement a mechanism for voluntary assessment of member physicians in order to certify them to be eligible for contracting with the health system. This certification is to be based on criteria provided by the AMA and medical specialty organizations and might include (but not be limited to): assessments of effectiveness (reduction of rates of morbidity and mortality); efficiency (use of practice guidelines, best practices, and cost control); and patient satisfaction. The major emphasis would be on educating physicians in a timely manner to state-of-the-art, evidence-based clinical breakthroughs. These findings are to be incorporated into "best practices" formats that are to be sufficiently flexible to allow for clinically appropriate treatment of all patients, with recognition of the unique aspects of each patient's clinical circumstances. The PERCO will provide the TDO with information on the ongoing certification of physicians for a reasonable fee. The data collected will be subject to analysis and research for the purpose of improving the quality of care. The practical advantages of certification would encourage physicians to apply best practices in their clinical work. The objective is to develop reimbursement formulas based on the adoption of best practices that do not penalize physicians who treat difficult or treatment-refractory patient populations requiring unique and unconventional approaches.

Due to antitrust considerations, the relationship between the PERCO and professional medical associations such as the AMA and the specialty societies must necessarily be at arms length. The societies' involvement would be limited to providing consultations in establishing certification criteria.

Physician Negotiation Organization (PNO)

The PNO is a not-for-profit, voluntary organization that negotiates the basic value of the reimbursement formula with the TDO through a "Black Box", "Messenger", and other techniques to conform with antitrust rules and regulations. The individual physician member of the PNO is allowed to maintain, unfettered, his/her existing and future participation in any entity that is organized vertically, such as a group practice, a physician

practitioner organization (PPO), or physician hospital organization (PHO). These entities will be free to negotiate a reimbursement rate with the TDO on their own if they wish to do so. Since they are organizations whose members share significant economic risk, they have the advantage of being able to engage in collective bargaining for their members.

Committee on Arbitration of Malpractice Issues

The committee on arbitration of malpractice issues is comprised of three members each from the TDO and the PERCO. The committee will review the pertinent issues of the cases presented for consideration and refer to an arbitration panel the appropriate cases for arbitration.

Relationship between the TDO and the allied professions

The TDO engages initially the members of the allied professions in negotiations for reimbursements for services individually, through groups and other vertically organized entities or through members of an organization modeled after a PNO. It may be feasible after the initial step in which the physicians have been integrated into the combined comprehensive model to take the next step and interact with the allied professionals by means of organizations patterned after the PERCO. This progression will depend on the particular allied professions successful effort to initiate an effective process of cost control as exemplified by the educational process, best practices format, and certification process of the PERCO. Until such evolution occurs the TDO will assert reasonable containment of cost by controlling the interventions of the allied professional members as it deems appropriate.

Possible strategies for incorporating existing funding streams into the Model:

An essential strategy in the implementation of the CCHCM is the inclusion not only of Medicaid and Medicare participants and those currently insured through their employers, but also of the marginally employed with inadequate insurance and those with no insurance. The latter will be achieved by supplementing their disposable income through a variety of strategies underwritten by federal and state governments. One model for utilizing existing funding streams might appear as follows:

Employed - health reimbursement arrangement (HRA) such as medical savings accounts (MSA) funded by the employer by a defined contribution and completely controlled by the employee.

Marginally Employed - MSA funded either by a tax credit or by a "health grant" or a combination of both from state and federal government, amount income dependent.

Unemployed and Retired without health benefit - "health grant" amount dependent on personal wealth" and income.

Medicare and Medicaid Inclusion - The federal and state government may enroll the members of these health care programs in the TDO, by depositing the funds directly to the TDO on behalf of the Medicaid and Medicare enrollees. This would give the federal and state government a means of influencing costs.

Issues to Consider:

How does this system differ from the existing Commercial Managed Care system?

- It places total control of the health care dollar in the hands of citizen-patients whose representatives control the TDO. There is separation between employers and the benefit.
- It allows an opportunity for the funds allocated for medical care to grow by investment and compounding; eventually any unused portion of these funds will be returned to the citizen-patients.

- It provides the citizen-patient with essential information necessary for making informed choices on health care and for taking responsibility for these choices.
- It is reasonable to assume that a significant amount of the 50% of the health care dollar, totaling up to 20 billion dollars, that is presently appropriated by the insurance and commercial managed care industries for profit, administrative costs, and marketing will be saved and used more productively within the health care system.
- Since the PERCO is a physician controlled organization, it will require less bureaucratic procedures than a Managed Care Organization (MCO).

The financial incentive for physicians will be placed on clinical competence, quality of care, and patient satisfaction, rather than on the limitation of care that results from capitation and other procedures currently used by the commercial managed care industry. Reducing the variation in physician practice by such means as best-practice algorithms would also serve to enhance quality of care, practitioner competence, and patient satisfaction; unlike the current managed care environment, the primary focus would not be perceived as targeting physician autonomy for the sake of corporate profitability. This shift in focus is more likely to elicit voluntary cooperation from physicians; and as physicians are responsible for directing the use of approximately 70 % of the medical resources, their greater cooperation will result in increased cost savings as it will encourage effectiveness and efficiency in the system. In summary, the shift in the focus to quality goals and the more effective use of practice guidelines and best-practice algorithms will improve the quality of care and lead to significant cost reductions as well.

What about physicians' resistance to being certified?

Certification of physicians provides a means of linking monetary compensation to the desirable goals of effectiveness and quality in the health care system. In addition, it will assist patients in making a judicious choice with regard to a physician. Since the certification process will be directed by the medical professionals, utilizing educational techniques to stimulate physicians to maintain their ongoing clinical skills, the process would be collegial in concept; it would not be designed as an adversarial process by which administrators can chastise or intimidate practitioners. A collegial, education-focused certification process is an essential ingredient in a well-functioning health care system. Since some sort of assessment is the wave of the future, it makes sense to ensure that this assessment is based on criteria that are fair, valid, effective, and acceptable to physicians. In this way the medical profession will stay ahead of the curve.

Will the use of best practices, algorithms, and guidelines foster "cook book medicine"?

Treating each patient according to his/her individual needs is a fundamental principle of medical practice; a sound, quality-based health system needs to incorporate this principle as well. The use of algorithms, etc. should not restrict the physician unduly to the point where he or she will not have alternative choices that best fit the needs of certain patients. The rationale for the use of best practices, etc. is to guide the physician towards the most appropriate alternative for the majority of patients in a timely fashion by bringing to bear state-of-the-art clinical advances in the clinical setting. They would not prevent a physician from using an alternative diagnostic or treatment approach that best suits the individual patient as long as the physician is able to offer a clinically-sound basis for choosing the alternative.

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