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Is Managed Care Really Just Another, Unethical Model T?

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On May 29, 1999, the American Psychological Association (APA) and the Virginia Academy of Clinical Psychologists applauded the decision by the United States District Court to block a federal Employee Retirement Income Security Act (ERISA) (1974) preemption that would have excluded Blue Cross Blue Shield of the National Capital Region from a lawsuit filed against Blue Cross Blue Shield and its HMO subsidiaries, CapitalCare, Inc., ValueOptions, Inc., Value Behavioral Health, Inc., and Health Management Strategies International, Inc. The lawsuit charged these insurance companies with fraud, breach of contract, and interference with the doctor/patient relationship ("Psychologists successful," 1999). Coupled with this, on June 21, 1999, a multibillion-dollar antitrust class action suit against mental health management companies responsible for the treatment of more than 115 million Americans continued to progress in federal court. The judge hearing the case denied a motion by nine of the largest mental health care firms to dismiss a suit that charges that managed behavioral health companies conspired to fix the prices they paid to mental health providers to maximize their profits such that their patients were denied adequate mental health care ("Federal judge," 1999). Finally, on June 29, 1999, the Senate, breaking a deadlock, agreed to take up patients' rights legislation that would set new controls on HMOs and other managed health care plans. Senate Minority Leader Tom Daschle told reporters, "This is a great victory for the 160 million Americans who are today demanding that Congress fix the problem in managed care" ("Senators spar," 1999, p. 5A).

There is little question that health care has undergone a dramatic change in the past decade, a change that many consumers, health care professionals, and politicians have not liked. Much like the reaction of the turn-of-the-century carriage makers to the advent of the noisy, smokey, and "dangerous" Model T, the advent of managed care has brought with it a variety of objections that decry the managed care monster and call for a return to the "good

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ole' times," to an era of limited accountability and substantial professional freedom. As a result of these types of pressures, changes are under way that will alter managed care and will change it from that which is currently in place. The reality is, however, that we are not going back to the good old days, and experts in health care generally agree that much like the Model T, managed care, in some form, is probably here to stay. As with the advent of the Model T, an innovation that resulted in the creation of new rules designed to improve the safety of those who used it and lived around it, managed care is also going to require the development of rules that are unique to it: rules that protect those who deliver managed care services and those who consume them. So, those who deliver health care services, and specifically those who provide mental health services, had better learn to live with this new type of cost-oriented accountability and how it has affected the delivery of mental health services.

As is so aptly pointed out by Cooper and Gottlieb (2000 [this issue]) in their article, "Ethical Issues With Managed Care: Challenges Facing Counseling Psychologists," the effect managed care has had on mental health practitioners has raised a variety of vexing ethical conundrums, if you will. These ethical problems must be addressed if psychologists are going to perform in a fashion that is consistent with the ethical principles of psychologists and code of conduct (ethics code) of the American Psychological Association (APA) (1992). More important, because this ethics code has been incorporated into the laws of many states, a failure to perform in accordance with the code could also result in licensing board action being taken against the psychologist. These two authors aptly point out how psychology must address the impact of managed care in three important areas: practice, research, and education. Although emphasizing the impact of managed care on counseling psychologists, the points made by these authors clearly apply to all who work in applied mental health, be they clinical psychologists, health psychologists, psychiatrists, master's level therapists, or other allied mental health professionals.

The article begins with the clear message that, when a psychologist deals with ethical issues, he or she must have some type of an understanding of the moral principles that drive ethical decision making. This knowledge will greatly help in the development of ethically based decisions. In addressing the basic components of ethics in health care, Cooper and Gottlieb (2000) refer to the seminal work by Beauchamp and Childress who, in their book, *Principles of Biomedical Ethics* (1994), outline the following four fundamental principles of ethics: autonomy, nonmaleficence, beneficence, and justice. These four principles are the foundation of most ethics codes and should become the primary point of reference in addressing and solving ethical conflicts. Simply put, a good health care professional should do good, not

bad, allow people choice and be fair (equal) in practice. To do otherwise places one in a moral conflict that can become ethically compromising and even legally complex. However, to many, the advent of managed care has created a very complex system that has challenged a mental health professional's ability to operate consistently within these principles. In addition, managed care has also brought with it a professionally risky model of professional practice, comprised not only of morally based obligations to the consumer of psychological services but of obligations to those who reimburse the provider for the delivery of services. Cooper and Gottlieb (2000) succinctly point out in their article that there is clear risk that, when psychologists attempt to fulfill their obligations to a managed care company, they may be placed in a position that compromises their ethical obligations to their clients.

In their review of how managed care affects the ethical practice of applied psychology, these authors review a rather extensive number of ethical problem areas frequently encountered by practitioners, each of which does not need to be repeated here. However, on review, many of the issues raised by these authors fall under the more general topic of informed consent, or the right of the consumer to fully understand the impact managed care will have on them and the types of professional services they are about to receive. As ethically mandated (APA, 1992), informed consent should occur as early as possible in the treatment process and, if at all possible, before therapy commences. This is due to the fact that informed consent is based on the ethical principle of autonomy, or the right of an individual to choose what happens to him or her. If managed care mandates have the potential of affecting the delivery of services either through service limitations, cost-containment strategies, or other contractual directives, the consumer must also understand this prior to commencing treatment. In truth, if a provider does not make sure that the consumer understands the complexity and constraints of this health care delivery system, they have failed to fulfill the mandates of informed consent (Koocher, 1998).

The significant error committed by many professionals around informed consent issues has to do with a false assumption that it only occurs at the outset of therapy. Cooper and Gottlieb (2000) emphasize that informed consent must occur at the beginning of therapy and, then, throughout therapy as goals and issues change, a point made in numerous other publications (Pope & Vasquez, 1991; Younggren, 1995, 1998). Although the application of this demanding principle is time consuming and, at times, fraught with details, it is likely to be much more complex when working within the additional constraints and requirements created by managed care. This is obviously due to the fact that the treatment a managed care provider is offering is often controlled by the managed care organization and by the individual contracts that

apply to the delivery of the mental health services at both the provider and the consumer level. However, because most consumers are unaware of the limitations, special conditions, and mandates created by a managed care delivery system, it is imperative that the provider outline them prior to treatment and continue to clarify them throughout the treatment process. A failure to do so also is a failure to fulfill informed consent.

The need to perform informed consent throughout therapy is furthered by the reality that, even under the best of circumstances, a psychologist could not provide complete informed consent at the outset of treatment. There will always be something left out. Even if one attempted to provide a comprehensive and necessarily lengthy informed consent, similar to the one distributed by the Insurance Trust of the American Psychological Association (Harris & Bennett, 1994), they would then be placed in the position of using up limited treatment time to discuss administrative issues that may not be relevant to the specifics of an individual case, another ethical dilemma. Thus, informed consent is better and more efficient when it is viewed as a dynamic and active process of exchange between therapist and client that occurs throughout treatment as it progresses and changes, and as problems arise.

With the above in mind, one aspect of informed consent that must occur prior to the beginning of therapy deals with confidentiality issues, because confidentiality is an area that is significantly affected by managed care (Barnett, 1998). The managed care provider not only must review traditional aspects of confidentiality and privilege with a client, he or she must also address managed care access to confidential information. The consumer of mental health services has a right to understand how much information is being shared with the managed care company, how that information is transmitted, and what becomes of the information after it is transmitted. Consumers have a right to understand that, if they are going to consume services under a managed care policy, the details of their treatment are going to be shared with an organization and that organization does not necessarily have to keep that information confidential. In addition, if the managed care organization will have access to records, therapy notes, and related materials, this reality must be set out clearly at the outset of therapy. Finally, the consumer must understand the way utilization review (UR) is conducted and just how much information is shared with the managed care organization to obtain authorizations for continued treatment. This point becomes much more relevant in light of the research that indicates that, although informed consent as a general process does not affect openness in therapy and, in fact, makes the psychologist appear more competent to the client (Sullivan, Martin, & Handlesman, 1993), the potential release of detailed confidential information to outside agencies and organizations does have an impact on a client's willingness to disclose (Kremer & Gesten, 1998; Nowell & Spruill, 1993).

Consequently, psychologists who provide therapy under managed care contracts that require access to the details of a patient's records are actually making a choice to potentially reduce the quality of the therapy they provide because openness is considered by most to be an important component of effective psychotherapy. One can only wonder whether operating under these types of constraints is, in and of itself, unethical conduct.

Cooper and Gottlieb (2000) point out another very important area that needs to be included when a psychologist performs informed consent under managed care contracts. This deals with the reality that, for some insurance companies, what is sold is often different from that which is delivered. Frequently, the consumer enters therapy with a false assumption that he or she is entitled to receive the maximum benefits outlined in his or her insurance manuals. However, a provider may know that these benefit maximums are only reserved for the most serious of cases and that, in all likelihood, there are going to be substantial limitations on what the consumer is actually going to receive. If these conditions exist, the psychologist has a moral and ethical obligation to include an explanation of "what you see is usually not what you get" as part of an informed consent to treatment.

This conflict becomes more ethically compromising when the managed care company tries to impose gag clauses that restrict the ability of the psychologist to point out this disparity (Miller, 1996). As so aptly pointed out by Cooper and Gottlieb (2000), the existence of a gag clause, explicit or implicit, creates an inherent conflict of interest for the psychologist and has potential for misleading the consumer into believing something that is untrue about his or her therapy. Providing managed care services within these types of constraints would not only be a violation of informed consent, the conflict of interest may be, in and of itself, an ethical violation (Ethical Standards 4.01d, 8.03 [APA, 1992]). It has to be acknowledged, however, that the disclosures of contractual realities and disparities could possibly result in a managed care organization viewing the provider as unwilling to be a team player. This could then result in a reduction of referrals or even in the termination of a provider contract through the implementation of the no-cause termination clause of the provider contract. However, providing services that are constrained by gag clauses violates a client's moral rights to freedom and autonomy and creates a truly unethical foundation for therapy.

One final valuable point made in this article that addresses practitioners deals with what a psychologist does when a client's benefits have run out and no further authorizations can or will be made. What are the ethical obligations here and how does one resolve the conflicts that naturally arise when this occurs? In addition, how does one prepare for this and what role does referral play in this process? Cooper and Gottlieb (2000) indicate that clients need to understand from the outset of therapy that the authorization process is

unpredictable and there is no guarantee that additional sessions will be granted. This clearly could be considered another aspect of informed consent. Then, if a request for additional sessions is denied, the client has already been prepared in some way for that eventuality/possibility. To quote from the authors, "It is not appropriate to terminate a therapeutic relationship without adequate notice, and practitioners should strive to provide a terminating interview whenever it is possible and appropriate" (Cooper & Gottlieb, 2000, p. 202). In reality, however, the preparation of the patient for the likelihood that future visits will not be authorized does not entirely remove abandonment possibilities. A provider must be prepared, in some way, to deal with a client who is in need of more services without further authorizations. In addition, and contrary to the authors' suggestion, a single termination session may not be enough to accomplish the task and offering no termination whatsoever is very poor risk management at best. In light of this, managed care providers have an ethical responsibility to address and deal with their client's emotional needs if they disagree with the managed care organization's determination that further treatment is not necessary. This means that one may need to provide services under some form of reduced compensation until the case can safely be closed, an appeal process with the managed care company has been completed, a crisis is passed, or an appropriate referral can be made.

This leads to the following question: Would a managed care provider have an ethical obligation to continue treatment without compensation? The answer to this is an obvious no, but the therapist who has lost compensation has a fiduciary obligation to make sure that immediate issues have been appropriately addressed such that the case can be terminated or until appropriate referral has been made. The provision of services in this way obviously reflects the attitude that the client's needs and welfare are a priority, behavior that is consistent with ethical morality. In addition, this conundrum is actually no different from the problems therapists have faced for years when a client's insurance was terminated or when their financial circumstances change such that they could not continue to pay for services. Under these circumstances, ethical professionals adjusted their practice and their fees in an attempt to solve the problem with a constant eye toward the welfare of the client.

One of the most valuable aspects of the Cooper and Gottlieb (2000) article deals with addressing the impact managed care has had on research and training. Too often, the ethical questions about the impact of managed care have focused on health care delivery with the absence of these two other areas that are potentially affected by it. In addition, it is from these two areas that solutions can possibly be found for many of the problems currently faced by practitioners in their dealings with managed care companies.

Cooper and Gottlieb (2000) believe that, when addressing ethical questions created by research conducted under the umbrella of, or funded by, managed care, the subtle pressures that could be raised by managed care companies' goals must be addressed. They point out that researchers must be cautious not to allow the goals of cost containment and efficiency to affect their objectivity in designing and conducting studies or on how they report the results of those studies. Nor must they allow the managed care company to serve as a gate keeper for the transmission of research results such that it censors reporting results of which it disapproves. Much like the unethical practitioner who adjusts what is best for a client to be consistent with managed care goals and to keep the managed care company happy, a researcher who adjusts the design of a study or who bends research results to support similar goals is equally unethical. In addition, a researcher who engaged in this type of conduct has become involved in a conflict of interest that has compromised his or her integrity and responsibility to the scientific community. Perhaps it would be best if researchers working with managed care companies would stay in touch with the reality that science may not be what the company is necessarily looking for, and if it is science that the company wants, then this could be limited to science that furthers the company's business goals and does not compromise them. Although psychologists have been trained to respect the reality that science does not take sides, the business world and, specifically, managed care companies do not necessarily share that view—thus, the increased risk to the managed care researcher.

The final area addressed by Cooper and Gottlieb (2000) deals with the responsibility training programs have to prepare students to survive in a managed care environment. Research would indicate that, in spite of the fact that managed care and its related problems have been in existence for years, the academic programs have been producing students with a business-as-usual foundation. Or, perhaps better said, a business-as-it-used-to-be foundation. Most programs continue to train students in long-term, dynamically based models of therapy that have little empirical validation (Nathan, 1998). Clearly, one must question the ethics of this when the marketplace where these young professionals plan to ply their trade is demanding something entirely different. In fact, the thesis put forth by the authors aptly raises the question as to whether such conduct is actually a violation of Standard 6.01 of the ethics code (APA, 1992). To add further emphasis to this point, they go on to state, "Given the far-reaching impact managed care will continue to have on psychologists, we contend that graduate programs are at a juncture where reform is urgently needed" (Cooper & Gottlieb, 2000, p. 216).

With the above in mind, training programs must address the reality of managed care. They need to prepare students to survive in a managed care environment in a manner that is consistent with good ethical practice. To do

this, they must welcome managed care into the academic setting and not exclude managed care because of its constraints and because it lacks the purity of open thought and free discourse. I fully concur with and applaud the authors' contention that educators must design a curriculum that addresses managed care and deals directly with the ethical conflicts created by a model of health care that is based on cost containment and efficiency. Finally, they must also place students in training settings that prepare them to survive in today's very competitive health care marketplace by giving them both administrative and clinical survival tools. Unlike the psychoanalysts of the 1950s who continually scoffed at, and rejected, behavioral interventions as not being reflective of real therapy, academic institutions will be better served if they accept the reality of managed care and work with it. Sending unprepared practitioners out into the competitive marketplace is truly unfair practice on the part of educators who have an ethical responsibility to educate and equip their students appropriately.

Those in academic settings also have an ethical obligation to serve as a resource for the development of materials that educate professionals about the changes in mental health care that have been brought about by managed care. It is here that they could have their most significant impact, not only on their own students but on those who are already practicing. Training programs need to coordinate with other professionally related organizations to review the relevant, managed care related research and to develop approved, ethically based guidelines that address managed care issues, and they must help to disseminate them to the psychological community at large. These research-based, ethically balanced guidelines could serve as a much needed resource for the psychologist who is attempting to arrive at an ethical solution to a conflict he or she is having with a managed care company. Today's provider is far too often placed in an ethical conflict with a managed care organization without the resources necessary to adequately defend against the pressures and constraints inherent in managed care, a situation that is only made more complex by the reality that the current ethics code was not designed to address managed care issues in any extensive fashion (Fisher & Younggren, 1997). A comprehensive set of professionally approved standards and guidelines, based on sound research and included as part of educational programs and endorsed by the profession at large, could be a most useful resource for the ethically challenged psychologist. This type of professional platform is badly needed.

One final point raised by the authors needs to be addressed. This deals with the unique role counseling psychologists can play in changing managed care and addressing the problems it has created. They state that because of the counseling psychologist's broadly based training, and because, as a professional body, counseling psychologists have been trained to provide services

that are time limited and symptom focused, they are likely to have the skills and knowledge that will allow them to cope with managed care and influence the direction of its evolution. Although this may be true, from the perspective of a clinical psychologist who struggles to understand the current differences between counseling psychology and clinical psychology, I contend that psychology as a unified body must adapt and address managed care as a changing reality. In addition, psychology as a unified whole must become involved in working with managed care to develop ethically based and clinically sound solutions to the problems it creates. Finally, psychology as a whole must become actively involved in helping the individual practitioner cope with the increased complexity that managed care has created in the provision of mental health services.

The Cooper and Gottlieb (2000) article aptly points out that there appears to be a consensus among health care professionals that managed care is not going away. Although managed care will change, it will remain a reality that was created by a number of factors, including greed and the rampant growth of the health care industry during the 1970s and 1980s. During that time, much was said about cost containment in health care, but until the advent of managed care, nothing much was actually done about it. Greed abounded and national health care costs spiraled to the point that they became a risk to the nation's economy as a whole. These conditions existed, costs escalated, and problems compounded until the business community became attracted to the economics of the industry, stepped in, took their cut of the funds, and changed it. Mental health professionals surely share in the blame for the creation of this change along with their medical counterparts. Consequently, there is little likelihood that health care will return to an unregulated fee-for-service business because the conditions that created the original economic problems have not disappeared.

So, although managed care will evolve, it will likely remain a present reality in some form. Unlike the carriage makers of the past, our industry had better learn to cope with the evolution of this new, unethical Model T. We must help to improve it to make it ethically sound and safer for all involved. Then, if we do this, we might eventually even make room for it in our garage next to our trusty old carriage. Finally, and as improvements are made in it, perhaps some day we could even learn to enjoy driving and riding in it. Perish the thought!

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