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# Ethical Dilemmas in Managed Mental Health Care

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In the United States, health care has become a significant political, social, economical, and ethical concern. It is difficult to identify a professional or personal area of life that is not impacted in some way by health care. According to the United States Census Bureau (2010) approximately 255 million Americans were enrolled in some form of managed health care in 2009. The current paper describes the evolution of managed care, common practices in managed care, and ethical issues inherent to working in a managed mental health care system.

## The Evolution of Managed Care

Traditionally health care services were provided on a fee-for-service basis, wherein consumers paid for rendered services out of personal funds, commonly referred to as out-of-pocket reimbursement (McFarland & George, 1995). By the 1940's employers had begun to provide their employees with indemnity insurance plans. Within these plans, health care services remained fee-for-service, but instead of the consumer paying directly, a large portion of the costs were covered by an insurer (McFarland & George, 1995).

By the 1970's, components of managed care began to emerge within indemnity plans (Rickel & Wise, 2000). For example, rather than reimburse a provider based upon his or her fee for a particular service, plans began to set reimbursement fee schedules which reimbursed providers a predetermined 'usual, customary, and reasonable' (UCR) fee based upon the service provided (Rickel & Wise, 2000). In addition, similar to current day managed care practice, indemnity plans required precertification (also referred to as preauthorization), for services and provided consumers with mental health and pharmaceutical benefits (Rickel & Wise, 2000). As Americans continued to utilize health care services at increasing rates, new forms of managing health care emerged in an effort to curtail rising costs (Bondeson & Jones, 2002).

## Managed Care

Managed care is a broad term that represents a service delivery system concerned with managing health care cost, quality, and access to services (Rickel & Wise, 2000). There are various systems that make up managed health care. These include Health Management Organizations (HMO's), Preferred Provider Organizations (PPO's), Exclusive Provider Organizations (EPO's), Point of Service (POS), Physician-Hospital Organizations (PHO's), Integrated Healthcare System (IHS), Specialty HMO's and PPO's, and Employee Assistance Programs (EAP's). Although there are various forms of managed care organizations (MCO's), they share common strategies to reach cost savings objectives. These strategies include capitation, quality assurance, gatekeeping, and incentives.

Capitated payment refers to the provision of a preset amount of services provided for a particular prepaid fee (Storm-Gottfried, 1998). For example, many health care policies limit the number of covered health care services, or apply a fixed dollar amount to such services. If a consumer exceeds the fixed allotment, those services are not covered by the MCO. Managed care companies rely on quality assurance mechanisms such as treatment reviews, consumer satisfaction surveys, and outcome measures in the development of managed care policies and processes. MCO's use this data to identify cost effective treatment approaches and then create policies to guide providers to employ these cost saving treatments.

Gatekeeping refers to strategies that require pre-approval for services or referrals from primary care physicians for specialist services. Through gatekeeping efforts, consumers are often directed to providers who have contracted with a MCO and have agreed to a reduced reimbursement rate for their services (Storm-Gottfried, 1998). MCO's also provide cost containment incentives to providers and consumers. For example, providers may receive

bonuses for meeting certain treatment objectives. MCO's motivate consumers to control health care costs through shared financial responsibility, such as with copayments, deductibles or increased costs for receiving services from an out-of-network provider (Storm-Gottfried, 1998).

## Ethical and Legal Issues in Managed Mental Health Care

Providers, consumers, and policymakers have expressed concern over the potential legal and ethical consequences posed to by managed mental health care to both consumers (Edmunds, 1997). Mental health care providers are bound by the ethical standards of their profession and by the laws that govern mental health practice in their state. The ethical standards that guide mental health professionals in their work often conflict with the ethical principles that guide business practices, such as those employed by MCO's.

Ethical and legal issues inherent in a managed care system differ in how each type of violation is addressed. Ethical violations are subject to consequential action by professional organizations, whereas legal violations are handled through state licensing boards (Corcoran & Vandiver, 1996). Some ethical violations also reflect violations of law. For example, confidentiality is a required ethical standard of all mental health professionals and it is also upheld by the legal system (Weiner & Wettstein, 1993).

### Confidentiality and Client Autonomy

Critics of MCO's have expressed disdain over how client autonomy and confidentiality are treated. Confidentiality is a foundational principle in the mental health field. It is considered an essential component of good practice among mental health practitioners as it provides clients with the freedom to their innermost thoughts and feelings (Chambliss, 2000).

Client confidentiality is based upon the ethical principle of autonomy, which refers to the belief that clients should be independent in making their decisions (Corcoran & Vandiver, 1996).

In the context of confidentiality, autonomy reflects the client's independent decision to enter into a confidential relationship with persons of their choosing and in determining the course of treatment. Although, clients sign consents authorizing the release of information required to process claims or to obtain treatment authorization, Austad, Hunter, and Morgan (1998) have argued that clients may not fully understand the potential consequences of their consent, especially those experiencing emotional distress.

The release of certain confidential treatment information to third-party administrators is necessary in order to receive treatment authorization and payment for services. This process is referred to as utilization review. At minimum, reviewers are privy to the client's diagnostic information and treatment plan. Managed mental health care reduces a client's autonomy by dictating much of what will transpire within the therapeutic context (Corcoran & Vandiver, 1996). For example, through required utilization reviews, MCO's possess the power to deny services based upon the proposed treatment plan. Therefore, the development of a treatment plan for the course of therapy is no longer a collaborative process involving only the clinician and client, but now involves a third-party.

**Informed Consent**

Similar to confidentiality, informed consent has both legal and ethical roots. Informed consent assumes that consumers cannot exercise autonomy without sufficient information. Informed consent must be voluntary, that is it cannot be obtained by way of deceit or duress. The person providing consent must also be competent, however; there is no consensus on what competence entails or in how it should be measured. Furthermore, the consent must be informed or knowledgeable (Petrila, 1998).

Health care providers have long had the ethical obligation of informing clients of pertinent health care information so that clients can make informed decisions about their health care (Storm-Gottfried, 1998). Traditionally, such information has included diagnoses, the nature of treatment, potential risks and benefits, and alternative treatment options. Clinicians working within a managed care system must also inform clients of cost considerations and business policies, including the nature of reimbursement through MCO's. Consumers must be informed of the extent of their mental health benefits and the procedures required of them and the provider to receive their benefits (McFarland & George, 1995).

**Conflicts of Interest**

Another area of significant ethical concern for practitioners working under managed care is the potential for conflicts of interest to arise between service providers and their clients (Koocher & Keith-Spiegel, 2008). Clinicians must balance the needs of their clients with the rewards, sanctions, and other incentives issued by the MCO. Blum (1992) refers to this dilemma as "double agentry" which refers to the notion that the providers loyalty and responsibility is not solely to the client, but also to the MCO, based on contractual obligations. For example, reimbursement structures and other incentives provided by the MCO may influence a clinician away from his or her obligation to work in the best interest of the client (Strom-Gottfried, 1998).

The most common conflict of interest to arise among practitioners working under managed care is when a MCO provides clinicians with financial incentives to alter or limit services to their clients (Koocher & Keith-Spiegel, 2008). Further a clinician may make a decision without the client's involvement in which the client may view as harmful.

**Access to Care**

While managed care has facilitated cost reductions and expanded services to include a broader range of individuals, it has been widely scrutinized for providing less than adequate care. Specifically, there is concern that the special needs of persons with substance abuse issues and the mentally ill may be neglected by the managed care system. For example, capitated payment and incentives promote negligent care of the severely mentally ill (Chambliss, 2000). Mental health consumers are often under the impression that their mental health needs will be covered under managed care and become frustrated upon the realization that there are several barriers that impede the receipt of sufficient care. Many policies cover stabilization or crisis intervention, but do not provide coverage for traditional forms of mental health treatment (Chambliss, 2000).

If MCO's deny services and clients are unable to fund their care out-of-pocket, often these individuals are referred to community mental health centers, which carries a host of new challenges. Many community mental health centers are short staffed which creates long waiting periods for clients. In addition, many staff members at community mental health clinics are not sufficiently trained in specialty areas that may be more appropriate in meeting the needs of special populations (Chambliss, 2000).

**Freedom of Choice**

A common argument among critics of managed care critics is that the provisions enforced by managed care limit clients' freedom to choose their own mental health provider. It is believed that selecting one's own therapist is an important step in promoting a strong working relationship (Austad, Hunter & Morgan, 1998). According to Karon (1995) forcing a client to choose a therapist from a select few within the network limits them to therapists that may be less qualified and less effective, simply to cut costs.

**Medical Necessity.**

Another ethical dilemma to access to services is the issue of medical necessity. The term medical necessity refers to level of severity and effectiveness of treatment. Under the provision of level of severity, a condition must impair a person's functioning in order for treatment to be deemed medically necessary. However, there is no consensus with regard to what extent a person must be impaired by a medical or mental health condition in order to justify treatment. The provision of effectiveness is met if it is determined that treatment will minimize the person's impairment. However, there is significant disagreement regarding what conditions are amenable to treatment and which are not. There are also disparities regarding which treatments will be the most efficient in producing desired results (McFarland & George, 1995). For this reason, MCO's are pressing health care providers to utilize evidence-based treatments in practice.

**Quality of Care**

Under utilization review, MCO's are gaining increasing control over the treatment received by mental health care consumers. Significant effort is being devoted by both public policy officials and by MCO's to increasing clinicians' adoption of evidence-based practice (EBP). Research related to evidence-based treatment has become a benchmark in determining what care will be approved by MCO's. EBP as it currently exists creates significant ethical dilemmas with respect to diverse groups and treatment effectiveness (Reed & Eisman, 2006). A major problem with use of EBP interventions is that little research has been devoted to the efficacy and effectiveness of their use with diverse populations (Sue & Zane, 2006).

The movement for EBP is aimed at providing evidence of empirically supported interventions for the treatment of specific mental disorders. However, if the client's presenting problem cannot be captured within a diagnostic categorization, but instead is the result of a

particular social climate, it is appropriate to question the efficacy of such evidence-based treatments with these persons. According to the U.S. Surgeon General (2001), there is a significant gap between research and practice among diverse groups, especially ethnic and racial minorities. Furthermore, Brown (2006) argues that the question of therapeutic efficacy may be most salient among clients who are gender atypical or who belong to sexual minority groups as these groups are rarely included in research investigating evidenced-based treatments.

## Conclusion

In summary, managed care emerged out of need to limit costs associated with growing utilization of health care services. The intentions behind a managed care system are cost containment and quality assurance. However, the strategies employed by managed care companies to minimize costs have received significant criticism. Inherent in the provisions set forth by MCO's are several ethical dilemmas that create frustration among clinicians and clients alike. Furthermore, many clinicians report feeling ill prepared to meet the challenges posed by managed care. Policy makers, providers, and consumers continue to work toward a reformed health care system that minimizes health care costs, while also maintaining an ethical standard of care.

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