MANAGED CARE: WHO MANAGES WHOM?

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This narrative presents dilemmas faced by mental health care practitioners in providing ethical treatment for clients within a managed care environment. As a private practitioner, the author negotiated for many years with managed care companies on behalf of clients. Often he would express frustration to his colleagues over the judgmental and suspicious manner with which he was treated by managed care clinical case managers. When hired as a clinical supervisor of a national managed mental health care company, he gained new understanding of the complexities of managing providers and clients in the delivery and receipt of efficient and effective care.

Note

The reflections of experiences by the author and the narratives of clients, clinical case managers, and providers have been altered only to the extent necessary to protect their identities and privacy. The managed care company is not named to protect the author.

Over 70% of the population of the United States is insured through private insurance, and managed care now dominates the financing of medical care among the non-elderly in the United States (Rosenbaum, Skivington & Praeger, 2002). In 2001, 93% of individuals with employer-sponsored health insurance were enrolled in some form of managed care, and only 7% remained in traditional indemnity plans (Gabel, Levitt, & Pickreign, 2001). Managed care plans promise costs lower than traditional plans largely through case-by-case utilization reviews conducted by clinical case managers (Rosenthal & Newhouse, 2002).

As a licensed mental health provider, employed both in the public sector and in private practice, I dealt with managed care regularly and quickly developed a strong aversion to their method of doing business. I found that decisions made by case managers appeared to be money based and were often at the expense of my client's medically necessary care.

Cost Containment: Who Benefits and Who Pays?

I received the call on the community mental health center crisis line at 4:00 in the afternoon. The caller identified herself, and a quick check on the computer confirmed that she was a client in the outpatient unit of the metropolitan mental health center where I was employed as a senior crisis clinician. Her voice was tense and fearful.

" ...I really don't know what to do. I'm afraid that I'm going to do something that will hurt my daughter...I don't want her hurt...I just don't want her to be hurt... I'm so scared." There was a flatness to her delivery and a slight pressure to her speech that concerned me.

After a brief conversation, it became clear that Cindy was in danger of harming herself. I asked her whether she had harmed herself previously and how she would go about harming herself now. She indicated that she had been involved in a very serious car accident three years ago while very depressed. She now attributed that experience as a suicide attempt.

"When I felt like this before, I ended up in the hospital. They say I was trying to kill myself, but I don't know. I just remember the overpass coming at me and hearing my mother's voice screaming at me about what

a bad person I was... she's always telling me how bad I am."

"Was your mother hurt in the accident?" I asked gently.

"No," Cindy hesitated, "she died when I was 13."

Further questioning suggested that Cindy was floridly psychotic and was experiencing command hallucinations—voices telling her, once again, to run her car into the side of an overpass. She appeared to have slipped back into the psychotic depression that had nearly taken her life three years ago. She was afraid for her safety and for the well being of her five-year-old daughter. I did not trust Cindy's ability to control the impulse to 'end it all' and 'stop the pain.' After talking a while more, Cindy was unable to promise me that she would not harm herself and agreed that she needed to be in the hospital for her own safety. She had a health insurance policy that covered inpatient mental health care and asked me to help her receive authorization to go to the hospital. I agreed.

I instructed Cindy to stay where she was, and after confirming that the agency had a release form on file granting us permission to speak with the managed care company I made a call to the case manager. I listened to a muzak version of almost all of "Strawberry Fields" before Paul Smith came on the line. There was no apology for the wait, only a sense of urgency...or was it impatience...as Paul agreed with me that the situation appeared serious and that certainly Cindy should have an assessment to determine the need for more intensive treatment. He assured me that he would consult with the crisis branch of the company to see what could be done. He agreed to call me back shortly.

When no call came within the hour, I called Paul back. He was not available, and another case manager informed me that Cindy had indeed been contacted and instructed to drive *30 miles* to the managed care clinic for a face-to-face evaluation. When I gasped in amazement and suggested that she and her daughter could be dead before they arrived, the case manager stated that it was their policy that a face-to-face evaluation be conducted prior to authorizing days for inpatient hospitalization. I asked to be notified as soon as Cindy arrived for the evaluation. With a sense of dread I called Cindy quickly, only to hear the beep of an answering machine on the other end.

Two hours later, I was surprised when the receptionist called to notify me that there was a walk-in crisis. It was Cindy. I was relieved to see her alive, daughter in hand. Once we settled into the office, she shared with me her past two hours.

"I drove to the center, like I was told, and they told me that I needed to be in the hospital, but they couldn't put me in because it wasn't serious enough yet." She paused, her eyes fixed on mine.

"I nearly stopped twice on the way over. My mother thinks I'm such a bad person. I kept hearing her voice telling me how awful I was, what a mess I had made of my life. I just want to stop her voice. Make her go away. There were five overpasses over to there, and I crawled through each one." Her eyes darted toward her daughter, who sat quietly in the adjacent chair.

"If my Lisa hadn't been there with me, I would have driven into the side of the overpass. There were three more on the way to here." Her eyes were glassy, her plea clear. "Please help me. Why can't someone help...Can you make sure my Lisa is safe?...I can't make my mother go away and I can't listen to her anymore."

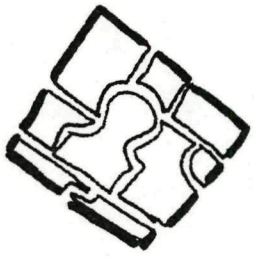
Cindy, highly suicidal and crying out for help, had been put in extreme danger by the actions (or lack of) of the company that managed her health care. Its unwillingness to authorize inpatient treatment for a highly suicidal client forced the community mental health center to involuntarily hospitalize a client who was, in fact, seeking voluntary admission.

With inpatient care denied by the managed care company, the only other option available to provide Cindy a safe environment in which to be assessed and stabilized was involuntary hospitalization. She was clearly a danger to herself and to her child, and was in need of inpatient care.

The treatment implications of involuntary versus voluntary treatment are profound. The sense of empowerment and self-determination that Cindy might have gained by receiving the help she was seeking was destroyed, with the consequence of subsequent inpatient treatment being imposed on her. With involuntary hospitalizations, the State takes on a paternalistic role and grants the mental health industry the right to force inpatient care on clients. The clinician serves as the 'jailer' of the psychiatric institution and holds the keys to a client's freedom; the clinician in the psychiatric hospital assumes a dominant position in the client's life and as such, his/her position as 'expert' is concretized. Given her involuntary admission status, Cindy would be treated as a resistant client, and her protestations to the contrary might be misconstrued and pathologized as the malingering of a manipulative client.

Why did the managed care company refuse treatment? Did they do it to avoid the expense of private hospitalization? The latent function of its negligence resulted in an involuntary hospital admission with the State paying the bill rather than the managed care company. Their actions prevented Cindy from accessing the health care benefits for which she was paying and, indeed, increased the possibility of her death.

What was the outcome of the process with Cindy? She received the care she needed and after two months was discharged from the state hospital. Cindy maintained custody of her daughter and continued outpatient treatment in the managed care outpatient clinic. The managed care company saved a mere several thousand dollars while gambling with Cindy's life, denying authorization for treatment, and forcing the State to pay for inpatient care. The stockholders of the company continued to increase their profits. Cost containment boosted corporate coffers at taxpayer expense...and at the psychological expense of the client, as I witnessed first hand in my office.



Client-in-a-Box

A colleague referred John, 45, to me. A survivor of ongoing childhood sexual abuse at the hands of his father, John had lived with his parents until the death of his father, six months past. He was experiencing clear symptoms of a major depressive episode. After completing the initial intake, I noted that John had insurance with a managed care company with whom I was a provider but with whom I had not previously worked. After reviewing the case with the clinical case manager, I was granted two sessions for the initial assessment. Standard practice. During my second session with John, it became clear that he had symptoms of post-traumatic stress and unresolved issues relating to the sexual perpetration by his father. The major depressive symptoms he was experiencing included thoughts of suicide, and he contracted with me not to act on these thoughts.

During my second contact with the case manager at the managed care company, I was told that I would be authorized four additional sessions to finish treatment with John. I was aghast.

"Do you understand that John has an extensive history of childhood sexual abuse and that he has clear symptoms of posttraumatic stress?" I asked. "You did receive both pages of the treatment plan, didn't you?"

"I understand your concern," she replied, "but it's generally our policy not to encourage the opening up of old traumas. John has lived and adapted to his past history of abuse. While he is scarred from the trauma, we can't support treatment aimed at reopening old

wounds. We encourage you to help John with the grief he has over the loss of his father and to point him toward a grief support group...support groups can be quite effective. We want you to view this as an adjustment issue."

"You've got to be kidding me," I blurted out, unable to contain my incredulity. "His father was his perpetrator. John's having flashbacks, nightmares, can't get these intrusive thoughts of death out of his mind...he's hardly slept in a week, and has lost 10 pounds. It's classic symptoms of PTSD."

"I hear that," was the reply. "Nonetheless, we are authorizing you to treat the bereavement issues and adjustment disorder, not the PTSD, and in cases of bereavement and adjustment disorder we authorize an average of six sessions total. It's our policy. You've already had two. You should be able to 'close up' the trauma issues within that time frame and provide some relief for the grief."

I made a couple of phone calls to some colleagues in the managed care business and was appalled to hear that this was standard practice. Managed care companies often have dozens of satellite outpatient care facilities around the country. They conduct analyses of care provided to thier clients at these outpatient clinics. From these analyses, an average number of sessions for treatment is attached to any diagnosis (much like DRGs). This company, therefore, had developed "best practices" expectations based solely on these averages.

While the case manager acknowledged my concerns, she stated that she could not authorize additional sessions unless there were extenuating circumstances. My client fell outside the norm. We had our six sessions, and our requests and appeals for additional sessions were denied. Ultimately, the client and I came to an agreed-upon out-of-pocket fee based on a sliding scale (some managed care companies now include prohibitions against out-of-pocket sliding scales in exchange for membership on their panel). Treatment concluded 18 months later with John beginning to untangle the grief and joy he felt at the death of his father, after having examined the impact the abusive relationship had on life. He had been attending a support group for adult survivors of sexual abuse for several months in town.

Experiences such as these left me with profound questions about the role of managed care in coordinating the providing of mental health services. Has the meaning and quality of human experience been quantified to the point that treatment for individual suffering can be predicted with such accuracy? Are managed care companies forcing providers to put their clients into boxes defined by symptoms, standard treatment models, and 'average' care? What happened to individuality and the unique experience of each client with whom we engage in practice? Are 'depressed' clients all expected to 'do' their depression the same way and respond similarly to treatment? Does the average number of sessions control for attrition? I know of at least one case in which a client committed suicide after one session with a clinician at a managed care clinic—is this considered termination of treatment and entered into the database determining treatment averages?

Into the Belly of the Beast

Like many clinicians, I have many more narratives I could tell relating to how managed care made my life and the lives of my clients miserable. I learned to view managed care clinical case managers with disdain, suspicion, distrust, and even contempt. But, alas, after my frequent lamentations about the evils of managed care and many episodes in which I cursed them soundly, I found myself working for the industry I so hated. How did this come about? I would like to say that I hoped to affect a positive change within the managed care industry by working within the system to effect radical social change, as Saul Alinsky

(1971) would suggest. While not entirely true, this would be the more noble explanation.

My explanation, consistent with the majority of my managed care colleagues at the time, was less noble: finances. Due to the limitations imposed by managed care, my private practice had become increasingly difficult to maintain, and I found myself in need of stable income to support my practice. The radical in me believes that I did affect some change from within the system, and that I served as role model to the case managers to whom I provided supervision. As an insider, I was able to assure ethical clinical decision making. The tension between the corporate bean counters and the clinicians was constant and at times aggressive. They pushed brief treatment aimed at maximizing cost containment; we pushed ethical treatment with a goal of minimizing client recidivism and maximizing client potential. In the end, the values of the clinical case managers won out over those of management, and the satellite shut down after hemorrhaging a quarter of a million dollars a month for nearly two years. Clients received appropriate treatment, but at a cost that the company ultimately could not afford.

In the meantime, I experienced a wealth of experiences that I use to this day in my courses and workshops on ethical treatment in a managed care environment. The following vignettes illustrate my experiences within the managed care industry, and explore ethical dilemmas with which I struggled and, in some cases, resolved within myself.

Conflicting Realities: Truth is in the Eye of the Beholder

The call came at the end of a long day. I had spoken with Dr. Brown on numerous occasions. She was in my catchment area and was known for "trying to squeeze everything she could out of the managed company." She had signed an agreement when she joined the panel of mental health providers that she would provide brief solution-focused treatment to clients. This was surprising because Dr. Brown was a trained psychoanalyst and had been providing psychoanalytically oriented treatment to clients for years in her practice.

I could always depend on hostility, anger, and confrontation when Dr. Brown called. This call was no different, and she wasted no time in ripping into me. She was highly agitated and was requesting authorization to treat a client, Jenny, whom she had been seeing for three years. Jenny had recently switched insurance policies and my company managed her current policy.

"...Jenny is highly suicidal and were it not for my work with her individually she would most certainly need to be hospitalized. Don't you people have a conscience?" she asked, angry at my authorization of only two sessions for assessment.

"I understand your anger, Dr. Brown," I explained patiently. "Jenny's symptoms are distressing and do suggest the need for further treatment. I'm not questioning the symptoms or the concerns around her suicidal thoughts. It's our policy, though, to authorize no more that two sessions for initial assessment and treatment."

Dr. Brown made no attempt to disguise her anger toward the company and me. "It will be on your head if Jenny dies, and there will be no one to blame but you. Don't you realize that she's going to kill herself if we discontinue treatment?"

I breathed deeply and gave a slow, measured reply. "It's important for you to understand that I am in no way denying treatment for Jenny. I'm simply asking for you to submit a treatment plan. I'm authorizing two sessions for you to conduct your assessment and to develop a plan for treatment. At that time we will in all likelihood authorize additional sessions, given the symptoms you've described."

"God damn it, why the hell do I have to beg for sessions two at a time when I have a

client who obviously is in need of long-term treatment? And why the hell do I have to explain any of this to you...*you bastard!* Who are you to second guess my clinical judgment?"

I took a deep breath and, as I started to respond, was greeted with a dial tone. Probably for the best I thought as I slid the phone back in the cradle. I sent along the authorization for two sessions and put the call out of my mind...until the next day.

When Jenny first identified herself as a client, I was surprised. It was seldom that I received calls directly from clients. In fact, this was the first in nearly a year. When the caller stated that she was a client of Dr. Brown, I steeled myself for an onslaught of anger directed at me for not authorizing additional sessions. What followed was a shock, as my earlier concerns about Jenny were quickly put to rest and replaced with growing unease about Dr. Brown.

"Hello...are you my case manager? I was hoping that you might be able to provide me with the names of some therapists." When I answered affirmatively, Jenny continued with somewhat more self-assurance.

"I've been with Dr. Brown for three years – she's a psychoanalyst – and I really feel that it is time for me to move on. It's just that I can't really afford to keep seeing her three times a week – it's bankrupting me." Jenny paused. "Is it possible to switch therapists?"

"Of course it's possible" I replied. "My job as your case manager is to make sure that you're getting the best care. Can you tell me what the problem is with Dr. Brown? You've seen her for quite some time. Do you mind helping me to understand what worked with her and what didn't? It may help me make some suggestions of people."

"Well, as I said, I've been seeing Dr. Brown for three years, and I feel as though I've developed a really unhealthy dependence on her." She paused. "She says that the dependence is part of the therapeutic process, and that I'm having this 'healthy transference' toward her as a 'bad object'. I think she just wants more money. I just get so angry when I drive up her driveway and see her beautiful house and her Mercedes while I'm eating peanut butter and jelly sandwiches and can't afford to have lights on at night. I feel like I'm just paying for her trips to the Islands..." Jenny hesitated. "This is confidential, isn't it?"

Assuring Jenny that I would not be speaking with Dr. Brown about the details of our conversation, I probed further. "It sounds like you're really tapped out, financially. I'm impressed that therapy has been so important to you."

"It is important, but I really started because of low self-esteem, and now, in hindsight, I feel that Dr. Brown took advantage of that and purposefully encouraged my dependence on her." She paused again.

"And when I express my worry about the cost of all this, she says that I have an unhealthy relationship with money and that we need to explore the meaning of money in my life, and my using it as an excuse not to do 'my work'...says I'm 'resistant'. She even increased my sessions from two to three per week to increase the tension I feel with money. When I initially said no, she said I was avoiding a deeply rooted problem..."

"I'm at the maximum of all my credit cards and she tells me that if treatment and getting better is really important to me, then I would not worry about the cost and would do whatever is necessary to support my getting healthy. I've become so angry with her, and still feel so dependent on her. Can you please refer me to another therapist?"

We discussed her situation a while longer before I gave her the names of two very well-respected brief therapists who could help her transition from what appeared to be a very unhealthy connection with Dr. Brown. It appeared that the biggest 'problem' in Jenny's life had become therapy itself and what appeared to be an exploitative therapist.

Jenny presented herself as highly intelligent, insightful, and very stable. During our conversation, I could not resist probing for any indications of suicidality. There were absolutely no indications of suicidal thought or intent. Jenny presented as articulate, very clear, and very professional. What a contrast to the irrational tirades of Dr. Brown who presented as angry, irrational, manipulative, and hostile.

Whose reality most closely reflects 'truth'? The provider? The client? The managed care case manager? Why are practitioners so quick to invalidate client experience by labeling it as "resistant" or "avoidant" or some other defense mechanism? When there is dissonance between therapist report and client report, why do we accept the perception of the provider over that of the client? Whose reality is it? In this case the licensing board was contacted and a report made. We discovered the complaint was not the first against this provider.

Through this experience with Jenny and Dr. Brown, I gained a profound appreciation for accepting a client's reality and lived experience over her therapist's interpretation and presentation of client symptomatology. Clients are the true experts of their lives and their experiences, and this needs to be honored. I also learned that while the motives of managed care companies are sometimes suspect, occasionally motives of therapists are equally questionable.

Playing Favorites

Beth was a 34-year-old woman in recovery from alcohol dependence. She had a severe trauma history, including repeated sexual abuse by her foster brother. The provider, Bill, had provided an Axis I diagnosis of Alcohol Dependence. The treatment plan also listed an Axis II diagnosis of Borderline Personality Disorder (BPD) traits. June, the case manager for the case and my supervisee, had been clear that no additional sessions should be authorized. She did not feel that a clear case had been made that Beth still met the criteria of Alcohol Dependence; she was in early full remission and hadn't had a drink in over three months. Additionally, June did not feel that she could authorize sessions for the diagnosis of BPD, as the client did not meet the full criteria for that disorder.

"You really seem to be struggling with this one, June. Why the ambivalence?" I asked.

"It's just that this woman has had so much happen to her in her life, and I really feel that she could benefit from some counseling...it's just that she just doesn't meet the criteria for either Borderline Personality or Alcohol Dependence...and that's what Bill lists as the diagnosis." She paused. "I just feel that she needs something here. I would hate to see her start drinking again. Isn't there some way that we can help her?"

"Well, we can't authorize anything based on Bill's request," I agreed. "Beth's not drinking anymore and she doesn't appear to be 'Borderline.'" I hesitated, as I reviewed the treatment plan further.

"There's some mention in here of early childhood abuse...what's that about? Do you know?" I asked. "Oh... wait a minute, is this the woman you told me about last week who had been molested by her foster brother and was later in a relationship with a violent man...that guy with the anger control problem?"

"Yeah," June replied. "Her brother physically and sexually abused her for quite a while, and her first husband landed her in Pavilion Hospital a couple of times, before she finally left him."

As we continued our discussion of the request for treatment, June shared with me symptoms and behaviors in Beth that were classic signs of PTSD, yet she had hesitated to authorize treatment because the provider had not listed PTSD as a diagnosis. I suggested her that she contact Bill and explore further the trauma history and whether he had considered approaching Beth on working on

her trauma issues. I wondered if Bill had misread the behaviors and characteristics of a trauma survivor as Borderline Personality characteristics and behaviors.

After June left, I reflected on what had just transpired in my office. I happened to be familiar with the work of the provider, Bill, and knew that he had a blind spot when it came to trauma. In addition, Bill was in recovery himself and tended to see everything through the 'lens' of recovery. He also had a most disturbing habit of diagnosing many of his 'trauma' clients with Borderline Personality Disorder and /or alcohol dependence. The symptoms on the initial treatment plan clearly suggested a diagnosis of PTSD, yet no mention whatsoever was made of this.

Was it appropriate for me to second guess the provider? Is it the role of the case manager to suggest possibly more appropriate diagnoses and treatment plans? To educate providers? To provide clinical supervision on cases? In both cases, working on trauma issues that each had experienced seemed far more appropriate than focusing on alcohol abuse and/or traits of a personality disorder. Indeed, dealing with the Acute Stress might prevent Pam from developing PTSD, the appropriate diagnosis if the symptoms of the event precipitating the acute stress response continue after one month.

Unfortunately, incompetence and/or inexperience among providers appeared to be as common as not. As a clinician, I chafe at being judged by a managed care case manager; as a past managed care case manager, I shudder at the many cases of unethical practice and incompetence (however well intended) to which I was exposed.

Taking Stock of Stocks

The managed care company attempted to co-opt my clinical judgment in numerous ways. First, I had a vested interest in decreasing utilization. As an employee of the company, I was able to purchase company stocks at 85% of their face value. I was overtly benefiting from the bottom line of a company in which profits in part were directly connected to decreasing utilization of services: 'we make money, you make money.' A conflict of interest thus existed between my clinical responsibility and the potential for my financial gain.

Managed care is a business whose business it is to increase profits and whose values center around money, not people. My company promotions and subsequent pay increases were tied to decreasing utilization and exhibiting good case management abilities (i.e., cost containment). Case managers most likely to be promoted were those willing to take hard stances on service utilization and able to show management that they could decrease utilization in a service area, thereby containing costs. Promotion in managed care is outcomes oriented, and outcome is defined as minimizing utilization without increasing liability. There was a clear benefit and incentive for case managers to deny requests for services.

I watched in amazement as a case manager known for his ruthlessness in denying authorizations was promoted to the position of Clinical Director of the company. The business-oriented company management rewarded productivity, which they defined as decreased utilization of services. Money is made by cost containment, money is lost by service authorization and delivery. The need to compromise one's integrity in order to be 'successful' in the managed care industry is very real.

Do compassionate case managers fall by the wayside and cut throat managers rise to the top? What is the incentive to show compassion to unseen and unknown faces? I watched time and again as those clinicians who shifted their focus from the good of the client to the good of the company were rewarded with bonuses and promotions. Unwilling to compromise my values and integrity to this degree, and frustrated that I could

not affect change from within the system, I left managed care after nine months for the academic world.

Lessons Learned

My time as a provider and as a managed care case manager has provided me with many insights. The lessons learned from my experiences are varied. Perhaps the most poignant lesson learned is that there are very powerful latent functions to privately managed mental health care. From frontline case managers to managed care CEOs, there are very real financial incentives to decrease client utilization of services. While the manifest function of managed care is to provide cost-efficient and effective mental health care to consumers, my experiences have made it clear to me that the latent function is individual and corporate profit and promotion.

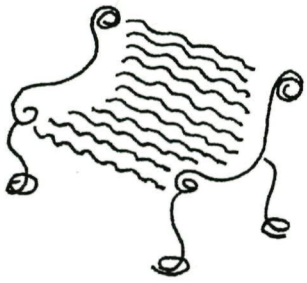
A corollary lesson is that managed care companies will play off the inability of the public sector to refuse treatment as a means of decreasing service utilization. The latent functions of such actions certainly save the managed care company a great deal of money, particularly when the per diem cost of inpatient care, for example, may run upwards of $1,000. Once admitted, a patient is seldom released before a minimum of a two-three day stay. The tension between publicly funded and privately funded mental health care is a powerful incentive for private managed care companies to 'dump' care responsibilities back onto the public agencies and institutions, who are not able to refuse or deny treatment.

Another powerful lesson for me is the nature of the so-called objective review of treatment plans and cases by clinical case managers. Managed care case managers would have us believe that their decisions to authorize sessions are made based on "objective" review of the medical necessity of treatment, when it is clear that treatment is impacted not only by the pressure to decrease utilization outlined above, but by the clinical case manager-provider relationship, by the personality characteristics and personal and professional experiences of the case managers.

Mental health assessment is a subjective process. Research clearly raises questions about the inter-rater reliability and the validity of diagnoses. There is not a single major study that shows that any version of the DSM has been used routinely with high reliability by regular mental health providers (Kutchins & Kirk, 1997). What became clear to me as a clinical case manager is that managed care by its very nature decreases the reliability of diagnoses and the length of treatment authorized. Diagnoses are more a function of what is covered by an individual's insurance policy than 'objective' presentation of client symptoms.

Confidentiality is by no means assured in a managed care environment. Extremely private information is being mailed and faxed around the country. If a wrong fax number is dialed, an individual's entire psychiatric history could be sent to the wrong party. I shudder when I recall the widely reported case in Massachusetts in which the entire psychiatric record of a woman was mailed to her podiatrist where she was seeking an appeal for denial of authorization for routine foot care. In the managed care company I worked with, we had two consultants, each located over a thousand miles away in the Midwest. One of the consultants regularly received faxes from his car fax machine that, he told me in an unguarded moment, his teenage son drove regularly. As managed care companies and health care providers begin to share confidential client records through the Internet, the implications are profound.

A final lesson for me is the 'game' that providers and clients are forced to play as participants in order to receive mental health services. Folks who do not know the rules of the game lose; clients with savvy providers



are more likely to receive treatment, and certainly more likely to receive extended rather than intermittent treatment. Managed care forces 'strategic manipulation' of the system in order to provide ethical services to clients. Managed care might call this insurance fraud; some case managers considered it the lesser of two evils.

Coda

Having experienced managed health care from the perspectives of both provider and clinical case manager, I can state with a fair level of comfort (and disappointment) that were I to choose to seek mental health services, I would not access my managed health plan. I would pay out of pocket. My experiences, as reflected in this article, leave me little confidence in the ability of the insurance industry to manage and coordinate my care. I certainly have not found any evidence that they truly would have my best interests at heart. I am fortunate to be in a position where I would be able to afford to pay out of pocket and not hassle with cost containment, treatment authorizations, case managers, appeals, labels, and the entire bureaucracy of managed care. For many people, especially those with no insurance, this would not be an option.

Is managed care contributing to a three-tiered system of mental health care in the United States: those who have no insurance, those who must use managed care, and those who choose to pay out of pocket? How do treatment and outcomes differ among these groups? Is it possible that those who are able to afford it receive more effective and ethical treatment through an unmanaged process? Perhaps through treatment that is based on a client's lived experience rather than a label required by the managed care industry? If so, then managed care will continue to evolve into an industry whose business is to contain costs through the provision of intermittent care for clients with the ultimate intent of increasing stockholder profits.

As for me, I left the managed care industry disillusioned and disgusted. Working on the inside of managed care convinced me that privately managed health care is untenable. The values inherent in a capitalistic system contradict the values of health and healing inherent in mental health service delivery. I live in the Northeast now, where I serve my penance for having worked in the managed care system by being an aging consumer whose health care services are now coordinated by the unseen faces of corporate managed health care case managers.

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