Currently there is a high degree of uncertainty and tension regarding the future economic viability of the U.S. health-care marketplace. A number of forces have the potential to contribute to market failure. At the time this chapter was written, the legality of the 2010 Patient Protection and Affordable Care Act (PPACA) was being challenged in the federal judicial system and attempts were being made in the U.S. Congress to repeal either part or all of the Act. However, even if the PPACA stays in full effect, additional actions will be needed in order to ensure that the needs and interests of the various stakeholders in the health-care enterprise are in dynamic and stable alignment in the marketplace. Additionally, the costs of health care will continue to rise unless controls are put in place to manage key escalating cost areas, such as pharmaceutical products and new technologies. Furthermore, competition among stakeholders has led to rapid consolidation of hospital systems, provider organizations, and health insurers. While such consolidation reduces fragmentation, it also creates turmoil in an already-unstable marketplace.

The U.S. health-care system has endured a turbulent, unremitting change cycle for more than three decades. It is truly a system in motion, configuring and reconfiguring itself on a regular basis. This turmoil is the result of attempts at economic reform, on the part of both business and government, motivated by the desire to reduce health-care costs. Consequently, the health-care system is being restructured around microeconomic principles, thereby causing a dramatic shift in the way that health-care services are organized, delivered, and financed. In the past, health care was seen as a profession in which professional authority held sway. Today, it has been transformed into a marketplace, where it is frequently treated like other commodities. Behavioral health care has also experienced significant change, notably in the way that it is financed and in its unfortunate segmentation from medical and surgical care. Today’s psychologists must function in a very different health-care environment from that which existed until the mid-1980s.

In many other developed countries in the world, health care is centralized, with the government both financing and paying for the care. This is not the case in the United States. The way that health care is financed in this country lies at the heart of the problems that the system faces today. The consumer (i.e., the patient) does not pay for most of the expenses associated with an episode of care. Rather, either the patient’s employer or a governmental agency bears the costs. The arrangement is called a third-party payer system, and the financing of health-care costs in the United States is completely dependent on it. Four out of every five dollars flowing into and supporting the health-care enterprise come not from consumers, but rather from the government or from employers, who subsidize health plan subscription costs for their employees. Medicare, Medicaid, and other local- and state-government-sponsored programs pay 45% of the nation’s health-care bills. Group health plans funded by employers as part of benefit packages pay 35% of the total cost and individuals or philanthropy pay 20% (Bardes, Shelley, & Schmidt, 2010).

Beginning in the 1970s, health-care costs began to increase dramatically, a trend that would continue into
the mid-1980s. As costs increased, businesses started to feel the strain on their profits and began to exert pressure on health plan administrators to contain costs. They were subsequently joined in this effort by state and federal governments that were eager to avoid imposing tax increases to pay for the escalating cost of health care. The concerted efforts of government and industry to contain costs have provided the impetus for economic reform in health care. However, cost containment has remained unattainable, due to a number of factors.

First, medical practitioners have been reluctant to change from a system of finance in which they dominated. From the late 1930s to the 1980s, the standard method of reimbursing providers and service facilities was the fee-for-service/third-party payer system (FFS/TPP). This system was built on provider-oriented principles that considered medical practitioners to be members of a protected class. It virtually eliminated price competition as a cost-containment mechanism and prevented microeconomic marketplace forces from operating naturally in the health-care system. An additional impediment to cost containment is the fact that the primary purchaser who provides health coverage (i.e., the employer or government) is not the recipient of the care. Patients who do not pay for care directly are largely unaware of the true costs of the care. Sometimes, physicians themselves are even uninformed about the true cost of care. Finally, it must be observed that it is not easy to change an industry that is grounded on the ethical principle that both life and quality of life are precious.

Although legislative reforms have not been as successful in containing costs as contemplated, they have led to dramatic changes. An entirely new health-care environment has been created, one with serious implications for all health-care stakeholders. Purchasers no longer blindly accept the cost increases of the FFS system; rather, they have become active promoters of price competition and restrictions on benefits. They no longer favor purchasing traditional indemnity or service insurance coverage; where permissible, they frequently self-insure, either passing on financial risk or engaging in shared financial risk arrangements with health plans. Health plans now find themselves in a difficult situation. Traditionally, they promised purchasers that they could reduce expenditures while retaining and even improving quality of care. However, this has proved daunting, because purchasers have continued to apply pressure to contain costs, while still expecting health plans to deliver the same level of quality. Increasingly, purchasers are asking their employees to participate in the cost-containment effort. Employers no longer just advocate for employees. They now support efforts by health plans to reduce expenditures. They attempt to increase employee cost sensitivity by forcing higher contributions to premiums and establishing higher copays, coinsurance, and deductibles.

The health-care environment is changing rapidly, and stakeholder roles and relationships are also changing. This chapter seeks to explain the forces driving that change within the context of marketplace dynamics. The chapter begins with a discussion of the primary stakeholders in health care and follows with a brief explanation of how two categories of forces—sustaining and disruptive—are able to shape a marketplace. Next described are the four distinct eras in health care from the late 1880s to the present: (a) the self-regulatory era, (b) the FFS/TPP era, (c) the cost-containment era, and (d) the newly emerging sponsored-competition era. During the first and second periods, stakeholder revolts against the prevailing system ultimately ushered in the next era, establishing the principles by which it would function. The market and service delivery features of the FFS/TPP era are described in detail, because they became the health-care standard against which a particular class of stakeholders (purchasers) revolted, thus initiating the cost-containment era. That revolt sought to replace the cost-increasing, noncompetitive features of the FFS/TPP system with market-based, price-competition approaches. Just prior to and during the cost-containment era, a number of disruptive innovations altered, and in some cases neutralized, important features of the FFS/TPP system, and these are examined. While the cost-containment era initially succeeded in containing costs during its early years, purchasers later began to experience significant increases in health coverage premiums, as did consumers who faced higher out-of-pocket expenditures. The growing need to develop new approaches to contain costs and the implicit recognition that action on the part of the federal government would be necessary to promote and guide the health-care change process played a large role in the initiation of the fourth era, the sponsored-competition era. The two major health-care pieces of federal legislation that provide the basis for the new era are discussed, and their implications for stakeholders, how services are delivered, and the role of psychologists are provided.

**STAKEHOLDERS AND THEIR STRATEGIES**

Marketplace dynamics operate continuously in the health-care arena. All free markets have stakeholder groups, which
are either part of the supply or part of the demand side of the market. The various stakeholders vie for supremacy, attempting to promote their own interests by modifying the market to achieve their particular economic goals. The stakeholders are often the instigators of two categories of change forces: sustaining forces and disruptive forces. Both types of change forces are capable of altering the marketplace dynamics, and the various stakeholders can and do employ them to further their own goals. The interplay and competition among stakeholders in the health-care marketplace has driven change for over a century.

The Four Stakeholders

The four key health-care stakeholder constituencies in the United States are (1) purchasers, (2) health plans, (3) providers, and (4) consumers. The purchasers (also known as payers) are largely the employers who pay a significant portion of health plan premiums for employees; governmental entities that pay for health-care costs for beneficiaries enrolled in their programs; and, to a much lesser extent, individual consumers who purchase an unsubsidized health plan directly. Numerous state and federal governmental entities also serve as the regulators of health care. Through antitrust enforcement, national and state rule-making authority, and legislative actions, governmental influence takes a large role in shaping and defining the health-care system in the United States. Health plans typically define and administer the benefit system used by the consumer, and contract with providers and their service facilities (particularly hospitals, care management organizations, pharmaceutical benefit management companies, and other groups) to provide health-care services for enrollees. Using a variety of insurance or financial arrangements, health plans contract with purchasers who pay premiums on behalf of employees or, in the case of governmental entities, on behalf of beneficiaries. The provider stakeholder constituency consists of the clinicians who provide care (physicians, psychologists, physical therapists, social workers, nurses, etc.), and the service facilities (hospitals, rehabilitation facilities, etc.) in which care is provided as well as the suppliers of pharmaceuticals and durable medical devices. Consumers, the largest stakeholder constituency, include the patients who receive care and the families affected by the nature and quality of the care provided.

Forces for Change: Sustaining and Disruptive Innovations

Even given the imperative for reduced health benefit expenditures stimulated by health-care purchasers, change of the magnitude being experienced in the health-care marketplace could not occur without additional powerful forces disrupting the status quo. Christensen, Bohmer, & Kenagy (2000) described two categories of change forces that have altered the way free markets operate and evolve. Sustaining innovations represent advancements that move technology forward, extend or expand capability, or improve diagnostic or surgical precision. Healthcare examples include: developing improved antibacterial and antiviral agents, improving and digitizing imaging of internal body systems, converting the patient health record from paper to electronic form, and enhanced telehealth capabilities. Sustaining innovations typically extend or enhance the prevailing technological or business paradigm, thus improving the effectiveness of services, or expanding the market and contributing to the escalation of health-care costs.

The second category of change forces is disruptive innovations. Because they significantly transform the prevailing business or technical paradigm, disruptive innovations create more turbulence than do sustaining innovations, and are therefore more difficult for some categories of stakeholders in the marketplace to incorporate to their advantage. Disruptive innovations are usually adopted when they decrease the cost of a product or service for the majority of the market by introducing new, more effective technology, service, or business models. Disruptive innovations typically make it possible for services to be provided with at least equal effectiveness for less cost.

About 35 years ago, the health-care system began to be bombarded by disruptive innovations aimed at changing the prevailing paradigms for finance systems and service delivery. These innovations are linked to a specific category of stakeholders: the purchasers. Normally, disruptive innovations in economic markets have direct, apparent benefits or appeal to the true consumer of the product or service. However, in health care, many of the recent disruptive innovations have benefited the purchaser, not the consumer. The two exceptions to this are the recently enacted Mental Health Parity and Addiction Equity Act (2008) and the Patient Protection and Affordable Care Act (2010), both of which are discussed later in this chapter.
the past 120 years, certain key historical actions have defined how health-care coverage is obtained, how services are financed, and how competition and choice operate in the health-care marketplace. It is possible to divide health care in the United States into four eras, employing a framework similar to Weller. (For a more detailed description of the social, political, and economic factors that transformed the health-care system prior to 1980, see Starr, 1982, and Weller, 1984.) The late 19th century can be characterized as the self-regulatory era of health care: A free-market environment for health care was operating and evolving, in response to the economic and social conditions of the time. This era ended as a result of actions taken by a particular stakeholder constituency: the provider, representing the interests of physicians and hospitals.

In the 1930s, a second era was launched, guided by provider-based principles and interests. It is known as the FFS/TPP era, and it would be the dominant health-care model until the mid-1980s. At that time another stakeholder group, the purchaser, revolted against the FFS/TPP system and initiated changes that resulted in the third era: the cost-containment era. This era lasted for about 25 years. During this period, the needs of the purchaser were dominant in the marketplace. With the advent of three disruptive innovations—the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and the Patient Protection and Affordable Care Act of 2010 (PPACA)—a fourth era is currently unfolding: the sponsored-competition era. This era, stimulated by legislation passed by the U.S. Congress, enhances the role of the federal government beyond that of a purchaser to a more prominent one as the managing sponsor of the change process across all stakeholder groups.

The Self-Regulatory Era

The self-regulatory era in health care began in the late 1800s and lasted into the 1930s. During this period, health care in the marketplace evolved naturally in response to existing conditions and without much governmental involvement or interference from professional associations of providers. In the beginning of this health-care era, stakeholders consisted primarily of consumers and providers (physicians and hospitals). Consumers were the purchasers of health-care services. They paid for care directly, usually by a per-visit charge. The physicians and hospitals were the sellers of health care. In addition to the predominant self-pay system, however, a new form of arranging and paying for health-care services emerged during this period. By the late 1800s, the leading manufacturing, mining, and transportation industries in the United States began to arrange and subsidize health-care services for their employees' job-related illnesses and injuries, particularly in rural areas where health care was virtually nonexistent. The industries found that they required a mechanism to ensure that care would be available when needed and that there would be a way to compensate the provider. They began to hire physicians as employees or, as became more common, went directly to health-care entities, usually hospitals, to develop contractual arrangements for the care of workers. These industries became a third stakeholder: the purchaser. The typical service delivery arrangement was a contract for care with a specific hospital and its associated physicians. The mechanism created to pay for that care was a prepaid payment system (now known as capitation) in which the employer agreed to pay a fixed amount to cover the anticipated health-care needs of its employees. Health-care costs would be covered by the contractual arrangement only if the employee received care from the contracted hospital or physician. Because these prepaid plans typically were linked to a single hospital and its core of affiliated physicians in a community, not all physicians or hospitals in a given community were eligible to participate.

Over time, and with the increasing economic uncertainty of the 1920s and 1930s, prepaid health plans proliferated. They diversified their plan structures; expanded benefits to include general medical care; and included arrangements with trade unions, fraternal organizations, employee associations, and other entities. As the Great Depression approached, consumers became anxious about access to health care. Hospitals began searching for financial vehicles to ensure a steady income stream. A robust market for prepaid health plans emerged, creating a price-competitive, self-regulatory market environment. Physicians and hospitals, however, began to resist this free-market system on the grounds that it divided physicians into economic entities competing for business on the basis of price. It also limited the ability of consumers to choose freely among all legally qualified physicians and did not include all hospitals and physicians in a given community. Physicians, through county and state medical societies and the American Medical Association (AMA), began to oppose the prepaid health plan arrangements and the resulting selective contracting and price competition. Their efforts were successful. The provider stakeholder community would eventually dismantle the self-regulatory era of health care. During this first era, however, several key elements of the nation's health-care finance and delivery system emerged. First, employer participation in the payment of employee health care was initiated. Although
the actual percentage of people receiving employer-financed health care remained small, the precedent of employer involvement would prove to be increasingly important throughout all future eras of health care. Second, group health plans were financed on a preservice payment system. This innovation introduced financial risk to the hospital-physician provider system. If the prepaid premium negotiated was insufficient to cover costs of care, the provider system still was obligated to provide the care. Third, the notion of selective contracting with hospitals and physicians was introduced. Without selective contracting it would not be possible for hospital-physician systems to divide into competing economic units vying for enrollees. Of course, without competing health-care systems, price competition, the fourth key element from this period, would have been severely curtailed. In short, a classic free-enterprise marketplace was unfolding in health care. It is significant that no stakeholder constituency was in a dominant market position relative to the other stakeholders. Providers, consumers, purchasers, and the health plans that increasingly emerged toward the end of the self-regulatory era were aligning and realigning themselves as marketplace conditions changed.

This period was notable for other reasons. It would demonstrate that a stakeholder constituency could, through concerted effort and under favorable conditions, dismantle a particular market system. This fact would not be lost on those promoting price competition during the cost-containment era. It also established a precedent for today’s price competition. Additionally, it established that provider organizations and hospitals were capable of contracting directly with employers and other organizations without using a third-party, managed-care organization or an insurance intermediary. However, a crucial concept was lost when the free-market system was destroyed: the ability to understand the relationship between price competition and quality of care. For all practical purposes, price competition was eliminated before its full and true effects could be discerned. The success of the provider community of physicians and hospitals working through their professional associations to defeat and eventually eliminate the self-regulatory era of price competition would be the first of two stakeholder revolts against a prevailing health-care finance and delivery system. Each revolt would lead to fundamental changes in health-care finance, delivery, and management, and would decidedly slant the marketplace in favor of the desires of the dominant stakeholders.

The Fee-for-Service/Third-Party Payer Era

The beginning of the FFS/TPP era of health care in the United States can be traced to the mid-1930s. At that point in time, provider advocacy organizations representing physicians and hospitals began to alter the existing free-market economic system for health care in a way that would be favorable to their membership. Weller (1984) described this as the guild free choice era because the provider organizations operated in a manner similar to guilds. At heart, the economic environment that was to be created would be anticompetitive: Each physician and each hospital would become a self-contained market free of competitive pressures. The manner in which the physicians and hospitals set about defeating the growing free-market health-care system of the 1930s would determine to a great degree the elements of the second era. They successfully shifted the health-care focus from the goal of the consumer and purchaser for a low-cost system to the needs of providers and facility operators. Because this provider revolt took place during the Great Depression, the advocacy organizations were able to operate without being as deeply concerned about antitrust actions as would be true today. Led primarily by the AMA, these organizations employed a three-part approach to assure that the interests of the medical community were met. First, they began a campaign to discredit prepayment plans. They drew the attention of both the consumer and the physician to the drawbacks of these plans—namely, restrictions on free choice of physicians—intimating that prepayment plans might fail financially and that “contract medicine” diminishes quality of care.

In the second and most effective part of the strategy, the AMA and the American Hospital Association (AHA) established policy positions that enumerated the principles and standards of their respective associations and were incorporated into the related medical ethics codes that practitioners were expected to follow. Through these actions, the AMA and AHA were able to blunt—and almost eliminate—hospital and physician participation in prepayment plans. Two key policy statements set the rules. In 1933, the AHA issued its policy on hospital participation in The Periodic Payment Plan for the Purchase of Hospital Care (Weller, 1984). Basically, this policy stipulated that group hospitalization plans should include all hospitals in each community in which a plan operates; that member benefits should apply at any hospital in which the person’s physician practices; and that all plans must be controlled and administered by nonprofit organizations largely composed of representatives of hospitals in good standing in the community.

Application of these principles in the marketplace would severely curtail price competition in the hospital sector. In 1934, the AMA House of Delegates adopted a policy stipulating 10 principles that it required private health
insurance plans to meet if they were to avoid resistance from the provider community (Starr, 1982). This policy in effect stated that all aspects of medical care should be controlled by the medical profession; that there should be no third-party intermediary in the medical care process; that there should be participation by any willing, legally qualified physician; that there should be no restrictions on patients’ choice of physicians; and, finally, that all aspects of medical care, regardless of setting, should remain under the control of a medical professional. Through application of these principles, “the AMA insisted that all health insurance plans accept the private physicians’ monopoly control of the medical market and complete authority over all aspects of medical institutions” (Starr, 1982, p. 300). These principles for private health plans were enforced through accreditation standards, and some were incorporated into state insurance codes and related association ethics codes. Physicians and hospitals faced significant consequences if they did not comply. In the third prong of the approach to changing the health-care system, the AMA did not oppose the development of health plans that were in keeping with its principles. Indeed, in the mid- to late-1930s, hospital systems and medical societies participated in establishing medical insurance plans that adhered to the policies and standards set forth by the AMA and AHA. Designed to compete against the existing commercial forms of health coverage, the first Blue Cross plans for hospital care reimbursement and Blue Shield health plans for physician services were established. They rapidly became the dominant forms of health insurance coverage. Fundamental to these plans was the elimination of price competition by including all hospitals of standing in a community in Blue Cross and community-wide eligibility for physician participation in Blue Shield. By achieving community-wide participation, the division of hospitals and physicians into competing economic units, in which closed panels of providers aligned with a specific hospital and competed for business with other similar systems, was effectively curtailed. Acceptance and enforcement of these principles in the marketplace and, in particular, in how health insurance was structured, brought to a close the self-regulatory era of health care. The variety of prepayment health plans and various health insurance arrangements of the self-regulatory era were replaced by two types of health insurance arrangements: indemnity and service plans. Indemnity plans reimbursed patients directly for most of the costs associated with health care. Patients paid the physicians directly, except for those too poor to pay at the time of service. Service plans, usually developed and managed under the watchful eyes of medical personnel, paid providers directly and usually for the full cost of care. Both types of plans were deemed acceptable because they respected physician sovereignty, kept intermediaries out of the care process, and minimized price competition. Having achieved a favorable structure for health insurance, professional associations more consistently embraced it as a financing mechanism for health care. Over time, the professionally derived and promulgated principles served as a blueprint for the structure of a new health-care market in which the finance and service delivery systems conformed to these principles. The emergence and refinement of this new marketplace structure coincided also with a several-decade upsurge in employer and government financing of health care. Sustaining innovations within the field of medicine during this same time were extending the range and effectiveness of medical care. Because in the new system physicians were paid a defined amount for each specific service provided and hospitals were reimbursed for their costs in providing care, it became known as the fee-for-service (FFS) system. The indemnity and service insurance entities created to pay providers and hospitals for services became known as third-party payers (TPPs), further highlighting the restriction of their role to that of financial intermediaries. The new system eventually became known as the FFS/TPP system. This system would increasingly dominate health-care finance and service delivery systems in the United States, fueling a 50-year period of prosperity for providers and service facilities. As the FFS/TPP system developed, certain of its marketplace and service delivery features became integral parts of almost every aspect of health care, from state insurance regulations to Medicare and Medicaid rules. In addition, the system set the guidelines for competition among providers and for relationships among health insurance intermediaries and physicians and patients. A close look at the system’s structure reveals that by nullifying price competition, it encouraged inflation of prices. This eventually would cause the FFS/TPP system to become the target of a number of purchaser-initiated disruptive innovations aimed at containing health-care costs by modifying or eliminating its key principles.

The FFS/TPP system also had a lasting effect on psychology. During this era, psychology matured as a health service profession and entered the marketplace as a provider group eligible for third-party reimbursement. As such, it had to abide by the principles of the marketplace. Being part of the health service provider profession, psychology structured its educational and training programs as well as its service delivery system to fit harmoniously within features of the system.
As the FFS/TPP system evolved and the principles on which it was based became entrenched in the marketplace, the following key features emerged:

1. The person who receives health care is typically not the true purchaser of that care. Rather, that person’s employer or a governmental entity usually finances a substantial portion of the costs associated with each episode of care. This is the central feature of the FFS/TPP system. A fundamental disconnect exists between the patient and the true cost and payment for medical care. Except for deductibles, copays, and coinsurance obligations, the patient is virtually unaware of the actual costs of an episode of care.

2. Care may be accessed without preauthorization. In the FFS/TPP indemnity insurance system, consumers have the right to access primary, specialty, and emergency care without obtaining preauthorization from health plan personnel. Medical necessity is determined largely by the provider, not by the insurer or the health plan.

3. The care reimbursement system must be open to all legally qualified providers. A central tenet of the FFS/TPP system is that it is a community-wide eligibility model that allows all legally qualified providers to participate. Health plans operated by insurers are not to contract selectively with providers by creating closed or limited panels of providers. This prohibition against horizontal market division ensures that each provider is a separate economic entity in the marketplace and significantly reduces price competition among providers.

4. Care management is the exclusive right of the provider. Fundamental to the FFS/TPP system is the principle that third parties, such as health plan personnel, should not be allowed to participate in utilization management of patients. Such decisions are to be made within the context of the provider–patient relationship without the involvement of an intermediary.

5. The FFS/TPP system is cost generating because of its capability to stimulate price-inelastic demand. The FFS/TPP system promotes price-inelastic as opposed to price-elastic demand. In a typical economic market, the price of a product or service is considered to be elastic if it is lowered to increase revenue. If a provider can raise revenue by increasing fees or by increasing utilization rates at the same or higher fees, demand is considered to be price inelastic (Enthoven, 1993).

The FFS/TPP era created a price-inelastic health-care system. Providers are reimbursed for each procedure performed and at a rate that equals the usual, customary, and reasonable (UCR) rate for that procedure in that provider community. Hospitals are reimbursed for the costs associated with providing care in their settings. Rather than having to reduce fees to increase revenue, as is typical in a competitive free market, providers and hospitals are able to stimulate demand for more procedures and then also raise revenue by increasing fees or charges. By engaging in a form of shadow pricing (i.e., raising charges for procedures, which then become reflected over time by increases in the UCR and cost of care reimbursement rates), providers and hospitals are able to increase the amount of revenue received from third-party payers.

6. Financial risk for health care is borne by purchasers and their contracted insurance carriers. The FFS/TPP system discourages providers and the facilities with which they are associated from joining forces to create a prepayment health plan and then marketing that plan directly to purchasers. In this way the system minimizes the amount of financial risk that providers and service facilities might incur in open-market arrangements. In the FFS/TPP indemnity insurance and service models, health insurers are largely financial intermediaries who pay providers and facility operators for the procedures and services provided to patients.

7. The FFS/TPP system delimits stakeholder roles in the marketplace. The principles on which the FFS/TPP system is constructed discourage cross-market competition. There is rigid segmentation or partitioning of the finance, service delivery, and management of health care according to stakeholder function. The system is designed to dissuade one type of stakeholder from taking on another’s role or function: for example, health plans combining an insurance function with a service delivery function or a purchaser contracting directly with a hospital and its medical staff. Keeping the health-care market segmented into distinct stakeholder roles prevents the division of providers and treatment facilities into economic units that compete with each other on price.

The FFS/TPP era is historically important not only because of the key features described above, but also because it demonstrated that a stakeholder constituency—the provider—could dramatically change the dynamics of the marketplace. Moreover, it could do so in a way that was favorable to its interests. While during the self-regulatory era no single stakeholder held a dominant position relative to the others, in the FFS/TPP era the provider
clearly dominated. Provider advocacy organizations attempted to confine all other stakeholders to a specific function in the marketplace. However, the conditions that spawned the proliferation of prepaid health plans during the self-regulatory era still prevailed in some industrial segments of the U.S. economy. This resulted in the need among some employers for the continuation of prepaid health coverage for employees. While the FFS/TPP principles minimized the presence of prepaid plans in the marketplace, prepaid plans were not entirely eliminated. Two examples of prepaid plans that emerged in the 1940s, evolved with changing marketplace forces and are in operation today are Kaiser Permanente and the Health Insurance Plan of New York (HIP). The impetus for the formation of what is now known as Kaiser Permanente was the need to provide health care to sick and injured workers involved in the construction of the Los Angeles Aqueduct (Kaiser Permanente History, n.d.). The Health Insurance Plan of New York, now part of a larger organization known as EmblemHealth Inc., was founded to provide limited low-cost medical care to middle-class workers in the New York City area (About HIP, n.d.). In addition, during this period, the health-care system in the United States became dependent on the third-party purchaser to provide the financial resources to fund health care. The elimination of price competition, the fact that consumers were increasingly cost unconscious, and the dramatic rise during the period in medicine’s capacity to intervene effectively in illnesses combined to create an expensive, heavily utilized health-care system with an enormous appetite for more funding. The stage was now set for a second revolution.

The Cost-Containment Era

The third era of health care in the United States began in earnest in the early 1980s when the purchasers, increasingly and with steadfastness, began to resist paying more for health plan coverage for their employees. Purchasers forced health plans—and eventually providers and facility operators as well—to reduce costs. Much like the previous stakeholder revolt led by providers, this one was aimed at eliminating those features of the prevailing health-care system that the stakeholder in revolt deemed objectionable. This time the focus was on eliminating the cost-increasing provisions and incentives of the FFS/TPP system.

Whereas the change effort of the previous rebellion was guided from the start by principles articulated by professional associations and enforced through their codes of ethics, the cost-containment era began without a guiding blueprint or mechanism for enforcement of changes in the health-care marketplace. Purchasers had a common goal of reducing the financial burden on employers and the government; however, they lacked a unified and clear strategy for reducing health-care expenditures. For this reason, the cost-containment era unfolded not as a concerted, well-orchestrated effort, but rather in reaction to a string of discrete disruptive innovations. These innovations have had the cumulative effect of changing the health-care finance and service delivery systems in profound ways, moving health care in the United States toward a price-competitive, market-based enterprise.

During the cost-containment era, five key disruptive innovations were either introduced into the health-care marketplace by the federal government, employers, or insurance intermediaries, or embraced by them as effective cost-saving measures. The first two innovations, the Employee Retirement Income Security Act (ERISA, 1974) and the Federal Tax Equity and Fiscal Responsibility Act (TEFRA, 1982), in effect paved the way for the emergence of the next two: managed competition and managed care. Managed competition would eventually provide a market-based framework for containing health-care costs; managed care would provide procedures for managing providers and consumers. Simultaneously introduced into the marketplace was the concept of carve-outs, in which segments of the health-care enterprise were selected for specialized management. Behavioral health care was one area selected to be carved out from the rest of the health-care system, along with the management of consumers’ pharmaceutical benefits and the management of chronic diseases. The importance of these disruptive innovations cannot be underestimated, as they continue to have a profound influence on the health-care marketplace. The following section describes these disruptive innovations, demonstrating how each changed an important feature of the finance or service delivery system of the previous FFS/TPP era or affected behavioral health care.

Employee Retirement Income Security Act

In 1974 ERISA became law. Prior to its passage, employers had to purchase health-care coverage through a state-regulated insurance carrier. After ERISA, businesses with 50 or more employees could self-insure their health benefits programs. ERISA would prove to be a vitally important disruptive innovation for several reasons. First, if employers chose to self-insure, they would not have to comply with state insurance regulations, including requirements to pay health insurance premium taxes and
to provide state-mandated health benefits. This preemption from state regulation has meant considerable savings for employers.

Second, because ERISA preempts employer-based self-insurance plans from state regulation, providers desiring to blunt or counter the effect of managed care on their practice would find the state legislative pathway to be of only marginal benefit. For example, after the introduction of managed care, providers wishing to eliminate the managed-care strategy of using limited provider panels by working toward the passage of “any willing legally qualified provider” statutes would discover that self-insurance plans are exempt from compliance with such laws. Thus, ERISA makes it more difficult for the provider stakeholders to counter managed-care arrangements, something they were able to do successfully in the 1930s.

Third, ERISA gave purchasers financial incentive to control costs, because any reduction in expenditures was retained by employers rather than becoming profit for an insurance carrier. The ability to retain savings from cost-containment activities provided ERISA’s greatest impact: changing the flow of the revenue stream in health care and providing a fertile environment for the growth of managed care, itself a disruptive innovation. Under the FFS/TPP system, the original revenue flow progressed from the purchaser to the indemnity insurance carrier. Revenue then passed through the carrier to the patient, who had already paid the provider directly. Over time, the insurance industry would develop service plans that would allow for direct reimbursement of the provider. Regardless of which way the provider was reimbursed, the insurance carrier in the FFS/TPP model was essentially a financial intermediary that did not meaningfully engage in cost-containment activities. Rather, the carrier simply provided reimbursement on an FFS basis, based on usual, customary, and reasonable (UCR) rates.

As employers availed themselves of the option to self-insure, they became more sophisticated health-care purchasers, able to intensify price competition in the marketplace. As a result, two new patterns of revenue flow emerged. In the first, revenue progressed from the purchaser to a cost-containment entity, usually a managed-care organization (MCO), before reaching the provider. The MCO became an intermediary working on behalf of the purchaser to contain costs by actively managing both providers and patients. MCOs limited access to the new revenue flow to those providers who accepted participation in cost-containment activities. MCOs thus became agents of change for the provider reimbursement and service delivery systems.

As MCOs evolved, they used more aggressive mechanisms to manage costs. They encouraged the formation of multispecialty provider organizations, channeling patients to those organizations via contracts. This accelerated the development of what became known as organized delivery systems (ODS) (Zelman, 1996). ODSs are groups of providers linked through various administrative and contractual arrangements to each other and to service facilities for the purpose of providing health care. As a result of their work with MCOs in cost-containment activities, ODSs have the capability of managing utilization, conducting quality improvement procedures, and even accepting financial risk for providing health care.

With the maturation of the ODSs, a second new pattern of revenue flow emerged, one that eliminated the MCO intermediary altogether. The success of managed care in getting these ODSs to assume financial risk via capitation or prepayment systems provided incentives for ODSs to improve their ability to reduce unnecessary utilization, manage quality of care, and carry out other care management functions. Many ODSs in essence were becoming provider-initiated and administered care management systems capable of controlling costs. Hence, a new, viable health-care avenue was available to purchasers. It created a fresh revenue stream that began with the purchasers who directly contracted with an ODS, eliminating both traditional insurance carriers and MCOs from the revenue stream. The increased viability of ODSs to engage in direct contracting with purchasers—combined with greater purchaser knowledge and competence in self-insuring health-care benefits—added a new dimension to price competition. The resulting tension created further instability in an already-unstable marketplace, as MCOs sought to limit the potential threat represented by independent ODSs.

ERISA has proven to be a particularly powerful disruptive innovation. By giving employers the right to self-insure, it enabled them to have more options in contracting with health plans, including bypassing the health plans and contracting directly with provider organizations. In essence, it simultaneously undermined another principle of the FFS system and elevated the purchaser to a position of greater authority over health plans in the marketplace. ERISA also gave rise to an intermediary in the caregiving process, one that identified with the needs of health plans and purchasers to contain costs. This had the effect of defeating another FFS principle: the prohibition of an intermediary from involvement in the physician–patient relationship. It also elevated health plan authority above the providers in a newly emerging stakeholder hierarchy.
Tax Equity and Fiscal Responsibility Act and the Prospective Payment System

The 1982 Federal Tax Equity and Fiscal Responsibility Act (TEFRA) was targeted at controlling Medicare costs, but it had an unexpected effect on all health-care costs and on behavioral health in particular. The most salient and well-known cost-containment mechanism proposed by TEFRA was *diagnostic related groups* (DRGs). DRGs contain costs by establishing the reimbursement rate that providers receive for treatment of a specific condition in advance. By setting fixed payment rates for inpatient treatment of certain medical procedures, DRGs create what has become known as the *prospective payment system* (PPS), yet another important modification of the existing FFS system. TEFRA moved reimbursement for inpatient hospital services from a fee per unit of service to a fee per episode of treatment. This was a radical change. Before DRGs, hospitals were reimbursed for all charges related to inpatient treatment. Through the use of DRGs, TEFRA set a specific number of patient days for which a hospital would be compensated for each specific illness or procedure. Whether a patient stayed more or fewer days than the prescribed number, hospitals received the same reimbursement rate. Strong incentives were thus created for hospitals to control treatment costs as a way to maximize profits, versus increasing utilization to maximize profits, as had been the case in the FFS/TPP era. The DRGs established as a result of TEFRA did not apply to behavioral health conditions, however. TEFRA codified what many health-care payers already knew: In behavioral health care, diagnosis of conditions did not lead to predictable treatment courses or reliable estimates for the time of treatment. Most providers of behavioral health care greeted the passage of TEFRA with great relief, not realizing that it would eventually lead to a greater separation of behavioral health care from the rest of medicine and cause it to be viewed as the chief spur to high inflation in health-care costs. In the absence of any other cost-containment mechanisms for behavioral health, mental health care emerged as the only sector of the inpatient market still operating under the unmodified FFS reimbursement method.

The health-care marketplace proved quick to adjust to regulatory changes. Some hospital corporations, which saw their revenues drop as a result of TEFRA, found relief by shifting their focus onto psychiatric inpatient care. Venture capitalists and entrepreneurs rushed in to take advantage of one of the last unregulated areas of the FFS system. Psychiatric inpatient facilities grew at a prolific rate, outstripping any reasonable projection for the need for inpatient care. Four large hospital corporations (Charter Hospitals, Community Psychiatric Center [CPC] Hospitals, Psychiatric Institutes of America, and the psychiatric division of HCA, Inc. [formerly Hospital Corporation of America]) saw double- and triple-digit growth in their facilities between 1980 and 1990 (Bassuk & Holland, 1987). A significant cause of the rapid rise in all health-care costs during that decade was the exploitation by hospitals and providers of the rich benefits for psychiatric inpatient care unregulated by DRG prospective payment methods. The standard of care for chemical dependency rapidly became 28 days, regardless of the severity or duration of the problem. Hospital stays became lengthy for behavioral health disorders. By the beginning of the 21st century, these same disorders would most commonly be treated on an outpatient basis. The excesses of the psychiatric hospitals came to a halt in the early 1990s due to high-profile investigations of their operations and subsequent significant fines (Lodge, 1994). For purchasers, there was perhaps no better marketing campaign for the emergence of managed behavioral-health-care organizations (MBHOs).

As a disruptive innovation, TEFRA made two important contributions to restructuring the health-care marketplace along cost-containment lines. First, by reintroducing a PPS, it overrode one of the basic principles of the FFS system. Second, it eventually resulted in a separate method for managing rising behavioral-health-care costs. Although no DRGs applicable to behavioral health inpatient care developed as a result of TEFRA, purchasers began seriously to seek other solutions to contain the steadily rising costs of behavioral health care. Eventually they would embrace *carve-out MBHOs*, the final disruptive innovation of the cost-containment era.

**Managed Competition**

In the early 1980s another disruptive innovation appeared. Enthoven and others began to propose ways to reintroduce price competition into the health-care marketplace (e.g., Ellwood & Enthoven, 1995; Enthoven, 1993; Enthoven & Kronick, 1989a, 1989b; Enthoven & Singer, 1997, 1998). The price competition movement that these authors stimulated eventually would become known as *managed competition*. Managed competition proposes to change the nature of the health-care marketplace in fundamental ways by introducing competitive pressures for cost containment and then managing how the marketplace responds to those pressures in order to prevent market failure. It intends to create conditions and forces that will compel health plans and their associated providers to manage carefully the...
care provided. The theory and strategies of managed competition guided the development of President Clinton’s proposed Health Security Act (1993).

Although Clinton’s efforts to secure passage of the Health Security Act ultimately failed to result in legislation, selected managed-competition principles, embedded in that Act, were adopted by purchasers during the cost-containment era.

Managed competition can be defined as the process of structuring the health-care marketplace so that rational microeconomic market forces produce a more cost-conscious, publicly accountable, quality-focused health-care system. In essence, managed competition is a blueprint for increasing competition in health care by structuring and managing a fluid market environment in such a way as to contain costs, while at the same time attempting to maintain quality of care and preventing market failure. Its fundamental goal is to change the health-care paradigm from exclusive reliance on the traditional FFS model to a managed-competition model that is capable of containing costs.

Table 24.1 compares specific elements of the FFS health-care system with the managed competition alternatives. An entire chain of change—a linked series of events among stakeholders—results from this alteration of the health-care paradigm. First, managed competition advocates the need to convert purchasers, especially employers, into sponsors of the change process. Then they must provide those sponsors with strategies designed to change the structure of the marketplace so that health plans operate equitably, and so that the more generally accepted microeconomic forces (e.g., supply and demand, price elasticity, etc.) operate to contain costs without sacrificing quality. If microeconomic forces fail to produce the desired competitive market, sponsors must adjust the strategies used to protect against market failure. Because the sponsors are really purchasers implementing managed competition strategies, they will most likely try to prevent market failure by having an effect on the stakeholders they influence the most: the health plans. In turn, health plans, in order to survive and gain market share, will need to influence the behavior of providers, service facilities, consumers, and the pharmaceutical industry through various managed-care arrangements.

Managed competition employs numerous strategies to accomplish its various goals. It aims to make the consumer more cost conscious and thus to change consumer behavior; it seeks to stimulate competition among health plans and to eliminate the noncompetitive features in the health-care system; and it has identified a particular stakeholder group, the purchaser, as a managing sponsor of the change process who would implement the key provisions of managed-competition strategies.

Making health plans compete for the business of purchasers on the basis of cost and quality through a competitive bidding process is a key strategy of managed competition. By standardizing plan benefits and requiring performance data, the bidding process enables purchasers to compare price and quality among various plans.

Managed competition also seeks to make the consumer more cost conscious by changing the manner in which premiums charged by health plans are subsidized by employers and the federal government. Managed-competition provisions would index an employer’s contributions to health plan premiums to the lowest-cost plan available to the employees. Those employees opting to enroll in a higher-cost health plan would have to pay the difference in premium charges between the lowest-cost plan and the plan chosen. The goal is to encourage consumers to be sensitive to cost when selecting among health plans offered during enrollment, thereby forcing health plans to contain costs in order to be attractive to potential enrollees.

<table>
<thead>
<tr>
<th>Traditional Fee for Service</th>
<th>Managed Competition</th>
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<tbody>
<tr>
<td>Separate finance and delivery of health care</td>
<td>Integrated finance, delivery, and health-care management</td>
</tr>
<tr>
<td>Competition for patients at individual provider level</td>
<td>Competition for patients at health plan level</td>
</tr>
<tr>
<td>All licensed providers eligible to participate</td>
<td>Selective and exclusive contracting with providers</td>
</tr>
<tr>
<td>Unfettered choice of provider by consumer</td>
<td>Restricted choice of provider</td>
</tr>
<tr>
<td>Solo practice or single-specialty practice groups</td>
<td>Integrated multispecialty practice associations</td>
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<tr>
<td>Inelastic price demand</td>
<td>Elastic price demand</td>
</tr>
<tr>
<td>Medical necessity determined by medical provider and consumer</td>
<td>Medical necessity determined by health plan</td>
</tr>
<tr>
<td>Nonstandardized insurance benefits packages with risk-based selection of enrollees</td>
<td>Standardized benefit and no risk selection</td>
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<tr>
<td>No financial risk for provider and facility operators</td>
<td>Financial risk to health plans and provider care organizations</td>
</tr>
<tr>
<td>Level of care continuum not managed</td>
<td>Level of care managed across entire continuum</td>
</tr>
<tr>
<td>Low cost attunement of consumer</td>
<td>Cost-sensitive consumer</td>
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Managed-competition proponents also call for changing government-based tax subsidies to ensure that competition is supported and promoted, as well as to encourage businesses to continue to provide health care for their employees. Managed competition has also set into motion certain initiatives focused on changing consumer behavior. It applies financial incentives to persuade consumers to accept reduced autonomy to initiate care and to accept a limited choice of providers. It attempts to intensify cost consciousness when the consumer contemplates using benefits by imposing higher copayments and coinsurance and by establishing financial penalties for not using the authorized provider system.

To stimulate competition among health plans, managed competition encourages the establishment of certain rules of equity. These are designed to structure the business environment in which health plans operate for the purpose of eliminating the noncompetitive features of the traditional FFS health insurance system. To accomplish this goal, health plans would be required to bid on standardized benefit packages so that purchasers can more easily compare premium rates. When benefits are standardized, it is more difficult for health plans to avoid enrolling potential high-cost consumers by not offering benefits that would adequately cover their care. Under managed-competition rules, payments to health plans would be risk-adjusted to ensure that the plans are adequately compensated for costs associated with the treatment of high-need patients. Furthermore, health plans are prevented from denying enrollment or limiting coverage for preexisting medical conditions. Once a person is enrolled, the health plan is guaranteed to be renewable, regardless of medical conditions, thus making coverage continuous. Health plans must accept all eligible participants who choose them. Finally, the premium level is set on a community-rating basis; that is, the premium charge is the same regardless of the health status of people eligible to enroll. Managed competition also seeks to promote direct competition among health plans in order to control costs without adversely affecting quality. To do so, it encourages the division of providers into competing economic units at the health plan level. It then encourages health plans to contract with distinct panels of providers in order to reduce the anticompetitive effects of competing health-care systems that have virtually identical or highly overlapping providers. An additional approach to deepening competition at the health plan and multispecialty level is to require these entities to provide performance data on patient satisfaction, access, and quality of care. By implementing these strategies, managed-competition advocates hope to make the provision of health care more price elastic, as compared with the inelastic price of the FFS system.

A final key strategy is to transform purchasers into sponsors of managed competition and then to develop a sponsor system. Sponsors contract with health plans for large groups of beneficiaries and manage the health-care market environment in a way that maintains price competition. A well-orchestrated, viable system of sponsors is central to the success of managed competition. Sponsors have several important roles. They must contain cost and maintain quality; take corrective action to protect against tendencies toward market failure in a fluid, evolving market; and guide the system in the direction of greater efficiency. In order for sponsors to gain the leverage necessary to structure and adjust the market, they must represent and purchase care for a substantial portion of the market.

The various strategies, collectively known as managed competition, were developed to be implemented as an interlocking package in an integrated and balanced way. If this does not occur, it is unlikely that the twin goals of producing a cost-conscious, price-competitive health-care environment and maintaining or improving the quality of care from that offered under the traditional FFS system could be achieved. There are obvious critical challenges to the full implementation of the managed-competition model. First, it must have the ability to decrease the fragmentation present in the purchaser segment of the marketplace and to create a sponsor system capable of managing change of the magnitude demanded. Second, health plans in managed-care systems must have the ability to develop sustainable partnerships with provider organizations. These provider organizations must be able to engender loyalty and develop allegiance among consumers, while simultaneously managing the care that they provide. Managed-competition strategies and challenges apply equally to the medical, surgical, and behavioral-health components of the health-care system. Their state of implementation and impact to date are described later in this chapter.

Managed competition is the third purchaser-linked disruptive innovation that occurred during the cost-containment era. Much like ERISA, it strengthened the authority of purchasers relative to the health plans with which they contract. It increased the number and effectiveness of strategies that purchasers had at their disposal to pressure health plans to contain costs, and it shifted a greater burden of the cost-containment mission to health plans. Once managed competition began, the stage was set for health plans to introduce two disruptive innovations of their own: managed care and carve-outs.
Managed Care

Unlike managed competition, which is aimed at restructuring the economic principles of health care, managed care attempts to influence the health-care behavior of providers and consumers. In the world of health-care finance, health plans and purchasers view providers and consumers as cost centers. MCOs were formed to enable health plans to satisfy the demands from purchasers that they contain or reduce expenditures. Following passage of ERISA, purchasers understood that if they self-insured their company’s health benefits and contracted with a health plan to manage costs, they could reduce premium increases for employees’ health-care benefits. Managed care consists of an evolving set of interventions focused on containing or reducing health-care expenditures, while attempting to maintain or enhance the quality of care provided. Although the cost reduction benefits accrue to the health-care purchaser, it falls to the health plans to implement managed-care strategies. In fact, as the health plan market consolidated, the term managed became virtually synonymous with health plans. During the cost-containment period, only a small fraction of health plans did not manage the care that patients received.

The beginning of attempts by purchasers to contain health-care costs can be traced back to passage of the 1973 Health Maintenance Organization (HMO) Act. Until recently, the standard HMO service delivery system was a multidisciplinary staff model clinic that integrated finance, management, and service delivery systems.

The proponents of HMOs hoped that these new staff model ODSs would stimulate price competition in the marketplace and eventually replace FFS systems, or at least force them to be more cost conscious. The competitive advantage that HMOs were supposed to have was based on their incentives to contain costs. Despite financial support for their development, the anticipated competition and reduction in costs never materialized. This prepayment method greatly increased the pressure on provider systems to contain costs by reducing expenditures. Managed care began to operate under a prepayment arrangement. This form of health-care finance became known as capitation, in which a specific amount of money is transferred from a health plan or managed-care entity to a provider organization to have that organization provide all the medical services a group of enrollees require for a specified time period. This prepayment method greatly increased the pressure on provider systems to contain costs by reducing expenditures. Capitation arrangements led to more aggressive utilization management, fears about denial of care, and concerns that quality of care would be sacrificed to maximize profits. As MCOs gained experience in controlling health-care expenditures, purchasers increasingly sought to contract with health plans that had strong managed-care systems. Despite the switch from unmanaged indemnity plans to managed-care plans, above-average inflation returned to health care by the dawn of the 21st century. This fact calls into question the actual effectiveness of the managed-care strategies that were intended to contain health-care expenditures. Perhaps the enduring contribution of this phase of the managed-care movement will be its disruption and nullification of key FFS principles in the marketplace. Specifically, it reintroduced the concept of financial risk to provider organizations, brought an intermediary deeper into the caregiving process, intensified selective contracting with
Carve-Outs and Behavioral Health Care

For behavioral health care, carve-outs represented the most important disruptive innovation developed to contain costs. They were introduced into the marketplace almost simultaneously with the larger managed-care movement. *Carve-outs* segment one health-care benefit from the rest, providing specialized administration and cost-containment controls to that segment. Pharmaceutical benefits, laboratory services, occupational medicine, and other benefits were subject to carve-outs. However, behavioral health care would experience the greatest impact from this disruptive innovation. Carve-outs were increasingly applied when costs rose significantly in a segment of the market, when it was difficult to determine medical necessity because of the level of provider discretion in determining the amounts or types of care given, or when the dynamics in that segment of the market were different from those that mainstream MCOs could handle effectively. Health plans and the purchasers with whom they interacted came to view behavioral health care as meeting all three of these criteria.

There is an inherent problem with carve-outs, however: They create an artificial division in the health-care continuum, in effect separating a part from the main body. Carve-out companies emerged that were separately financed, and they developed independent service delivery systems. These service delivery systems were often inconvenient. For example, when laboratory services are carved out, there can be a lack of integration of that function within the medical practitioner’s office. The patient must go to a separate facility for laboratory work, frequently having to fill out additional paperwork and then wait for service. There sometimes can be difficulty in reintegrating the information into the physician’s setting in a timely fashion.

Behavioral-health-care carve-outs posed a more serious problem. Because functions overlap between primary care and behavioral health care, consumers may not know where to access care for behavioral health concerns. In fact, a significant portion of behavioral health care is still provided by primary care physicians. Even more serious, behavioral health carve-outs made it more difficult to coordinate care for a broad range of chronic medical conditions that have high comorbidity rates for behavioral health problems. In addition, they impeded the ability of the rest of the health-care system to utilize fully the skills of the behavioral health specialist. Such specialists have the capability to help patients change health practices or make lifestyle adjustments that would prevent chronic health conditions from developing or prevent exacerbating already-existing conditions. Behavioral-health carve-outs have come to have broader implications than being simply a different company managing mental health benefits; they have also come to represent a separation of the skills of the behavioral health specialist from the broader needs of medical- and surgical-care patients.

Behavioral health care was among the first areas singled out by health plans for management via carve-outs. The use of carve-outs as cost-containment strategies in behavioral health care gave rise to a new form of MCO, the managed behavioral-health-care organization (MBHO). Two distinct types of MBHOs quickly emerged: the multidisciplinary staff model clinic (the clinic model) and the external intermediary utilization review organization (the network model). The clinic-model MBHOs were staffed by salaried providers and were often funded by capitation, a new form of financial risk taking that was similar to the older prepayment system of the self-regulatory era. Capitation funding arrangements pay a fixed dollar amount per enrollee per month or year to a clinic; the clinic in turn is expected to provide all medically necessary behavioral health care. Capitation funding is viewed by purchasers as a method to predetermine their costs for behavioral health care and as a way to create incentives for providers and their clinics to contain costs.

The early clinic-model carve-out MBHOs frequently had contracts with one or more local employers to provide behavioral-health-care services. Direct contracting with purchasers gave these companies a connection to employers similar to the ones that had developed during the self-regulatory era. Seeing a business opportunity, entrepreneurs quickly began to develop clinic-model carve-out companies in behavioral health care. Soon a variety of clinic-model MBHOs became active in the marketplace. Despite their variety, they continued to manage utilization and coordinate care internally. No external intermediary was involved in utilization management. The network model represents the second type of MBHO to develop. It grew out of utilization review organizations that had been active for several years in general medical and rehabilitation care sectors of the health-care market. These organizations saw the opportunity to expand into behavioral health care. They extended and modified their care management and utilization control procedures and then began marketing themselves to purchasers as MBHOs. Initially, the utilization review organizations did not have contractual relationships with providers; their only contact was...
with purchasers to contain costs. Unlike the clinic model, these companies did not directly employ behavioral-health-care providers. They contracted with providers on a discounted, FFS basis. One key element of the contract was the provider’s agreement to abide by the company’s utilization management standards.

Impact of the Cost-Containment Era of Health Care: An Analysis

The disruptive innovations associated with the cost-containment era had a profound effect on reshaping the structure and dynamics of the health-care system. Unlike the FFS/TPP era, where stakeholder functions were carefully defined and stakeholders were confined to their assigned role in the health-care system, during the cost-containment era, stakeholders were free to perform multiple functions, including those of other stakeholders. Purchasers could directly contract with provider health-care organizations; health plans could form their own provider organizations and be involved in service delivery; and purchasers could assume insurance functions through self-insurance arrangements. The cost-containment era rearranged the players in the stakeholder hierarchy. The provider stakeholder community no longer occupied the dominant position, and in fact, providers slipped below both the purchasers and the health plan stakeholders on the hierarchy. During this era, purchasers exerted their dominant position by emphasizing cost containment as a necessity. They influenced the behavior of the two stakeholder constituencies with which they had direct contact: health plans and employees. They applied pressure to health plans to contain costs and shifted a greater cost-sharing burden to employees and beneficiaries who utilized their health-care benefits. As initiators of the cost-containment era, purchasers have been its main beneficiaries. Ever since purchasers gained the right to self-insure their health-care programs as a result of ERISA, their power relative to health plan stakeholders has increased. Therefore, health plans and their care management systems occupy the pressure-filled environment where the demands of the purchaser and consumer must be balanced with the dissatisfaction and demands of the provider community.

The provider stakeholder community experienced the brunt of the cost-containment changes. No longer dominant in the stakeholder hierarchy, providers were now situated below both purchasers and health plans. The hardest blow was the defeat of the protections offered by the FFS principles. Providers have had to cope with an intermedial becoming involved in the provider–patient relationship, selective contracting by MCOs, increased administrative costs, decreased rates of reimbursement, and, in some cases, assumption of financial risk. The provider protections that were built into the FFS-era market structure have been largely nullified, and to date, providers have been ineffective in establishing a new path to market-place supremacy. The consumer stakeholder community has experienced much of the discomfort resident in the cost-containment era. The right to access care that is unimpeded by precertification procedures has been diminished, and purchasers have required employees or beneficiaries to pay a larger share of their health-care premiums and service costs.

The cost-containment era lived up to its label in that the concern for containing costs by purchasers and the competition of health plans for market share resulted in health plans’ efforts to contain costs exceeding initiatives to improve quality. Despite this reality, some important quality improvement efforts succeeded during this era. First, health plans transitioned from operating basically passive-reactive health-care systems to embracing provision of proactive assistance to help avert medical crises, decrease avoidable service utilization, and improve the health status of their consumers, and in so doing gained important insights into population health dynamics that will be beneficial during the subsequent era of health care. Second, they contributed to reducing fragmentation in the provider stakeholder community by stimulating the development and growth of organized delivery systems of provider groups and facilities owners and operators capable of providing a full continuum of care, accepting financial risk, managing utilization, and attending to quality of care issues. Third, as the cost-containment era unfolded significant gains were made in utilizing information technology and other technological advancements to assist in helping consumers maintain or improve health status. Fourth, experiencing increasing pressure to contain costs to stay competitive and retain market share, health plans sought and succeeded in closing gaps in the continuum of services available to consumers. Behavioral health care profited substantially from the addition of services to its continuum of care, with the addition of partial hospitalization programs, intensive outpatient programs, and chemical dependency programs. Fifth, viable care management programs emerged during this era for consumers with diseases that were persistent and required both treatment from a health-care professional and patient self-management initiatives, such as establishing positive
health supporting behaviors and eliminating health-destroying activities. Finally, improvement in information technology made it possible to more easily and accurately identify, communicate, and deliver targeted interventions and advice to those coping with unremitting health conditions.

Notwithstanding the achievements of this era, clear indicators of market failure were emerging with the return of high inflation rates during the last decade of the cost-containment era. Paramount among the reasons contributing to market failure was that the complete constellation of managed-competition principles, which to be effective should be implemented as a complete and integrated package, were implemented selectively and almost exclusively by one class of stakeholders: the health plans. Managed competition calls for the purchasers to consolidate their buying power to the degree necessary to serve as sponsors and managers of the change process who then balance the interests of all stakeholders. This did not happen, because nongovernmental purchasers failed to reduce their market fragmentation and no meaningful plan emerged as to how they would fulfill this role. Thus, no change management entity existed to guide implementation of cost control procedures, resulting in each class of stakeholders more narrowly pursuing their own interests.

In retrospect, the success of the cost-containment era was compromised from the start due to several key factors: the lack of an effective change sponsor, selective application of managed competition principles, insufficient standards or rules of equity in the health insurance industry, and provider and consumer resistance to the changing health-care landscape. These as well as other issues, would lead to a new era in health-care reform: the era of sponsored competition.

The Sponsored-Competition Era

As previously mentioned, the cost-containment era lacked an effective change sponsor. Since 1996, however, the federal government has been increasingly taking on this role. Much as the dynamics of the cost-containment era were highly influenced by the provisions contained in ERISA and TEFRA, the sponsored-competition era was initiated by the passage of three health-care-focused pieces of legislation: the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity and Addictions Equity Act, enacted in 2008, and the Patient Protection and Affordable Care Act of 2010. All three of these acts demonstrate the growing role of the federal government in financing the health-care system, establishing the marketplace rules that govern the way the system performs, and monitoring and adjusting marketplace forces to reduce the possibility of market failure. The Health Insurance Portability and Accountability Act (HIPAA) mandates that anyone belonging to a group health insurance plan must be allowed to continue their health insurance upon termination of their employment by purchasing health insurance coverage through their previous employer. In addition, the law also creates strict standards concerning privacy of health information in order to prevent improper use of one’s medical record. The Mental Health Parity and Addictions Equity Act (MHPAEA) is fundamentally a managed-care reform act designed to remedy unequal treatment limitations and consumer financial obligations imposed for mental health and substance use disorders that were not similarly applied to medical and surgical care. The Patient Protection and Affordable Care Act of 2010 (PPACA) is intended to change substantially the U.S. health-care system. At its core, the PPACA is a governmentally derived strategy to structure the U.S. health-care marketplace around principles consistent with managed-competition theory, so that rational, microeconomic forces operate more in concert to produce functional price competition at the health plan and provider stakeholder level, and to promote price sensitivity among the purchaser and consumer stakeholder communities. The following sections of this chapter present a more complete review of the major provisions of these acts, as well as how they are designed to transform the U.S. health-care system, and their impact on behavioral health care and psychologists in particular.

Health Insurance Portability and Accountability Act (1996)

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. Title I of HIPAA protects health insurance coverage for employees and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) rules, required the establishment of national standards for electronic health-care transactions. HIPAA set the stage for improvements in coverage as well as the basis for electronic transactions that lead to the modernization of the health-care system.

Title I of HIPAA regulates the availability of group health plans and certain individual health insurance policies. The law mandated that anyone belonging to a group health insurance plan must be allowed to purchase health insurance when previously provided coverage is lost. Title I also limited restrictions that a group health plan can place
on benefits for preexisting conditions. Under HIPAA regulations group health plans could refuse to provide benefits relating to preexisting conditions for a period of up to 12 months. However, individuals could reduce this exclusion period if they had group health plan coverage or health insurance prior to enrolling in the plan.

Title II of HIPAA created strict standards dealing with the privacy of health information, which helps prevent improper use and disclosure of an individual’s medical record. However, the most significant provisions of Title II are its Administrative Simplification rules. Title II required the Department of Health and Human Services (HHS) to draft rules aimed at increasing the efficiency of the health-care system by creating standards for the use and distribution of health-care information. The rules established by HHS applied to health plans, health-care clearinghouses, billing services, community health information systems, and health-care providers that transmit health-care data.

Mental Health Parity and Addictions Equity Act (2008)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) prohibits group health plans that have elected to provide either mental health or substance use disorder benefits from imposing more restrictive financial requirements or treatment limitations on the use of those benefits than those applied to medical and surgical benefits. The MHPAEA covers all health plans except for Medicaid Managed Care Plans, which will be subject to regulations issued by the Center for Medical Services, and Medicare Advantage plans that are not group plans sponsored by an employer. The federal Departments of Labor, Treasury, and Health and Human Services were stipulated as being responsible for producing implementing rules and regulations, which were subsequently published as an “Interim Final Rule” (Rule) in the Federal Register on February 2, 2010. The Rule updates the 1996 federal mental health parity law that applied to annual and lifetime dollar maximums for mental health benefits only, to be extended to benefits for substance use disorders (U.S. Department of Labor, 2008).

The Rule establishes six classifications of benefits and specifies that parity must be achieved on a classification-by-classification basis, which means that if a plan provides medical or surgical benefits in one classification and it also provides mental health and substance use disorder benefits, it must also provide those benefits in that classification as well. The six classifications are: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription medications, and emergency services.

The Rule also specifies that each type of financial requirement (copayments, coinsurance, annual dollar limits), quantitative treatment limitation (limits on number-of-days, visits, treatment episodes, etc.), and non-quantitative limitations (formulary design for prescription drugs, methods for determining usual, customary, and reasonable charges, etc.) applied to mental health and substance use disorders be the same or less restrictive than those applied to medical and surgical benefits under the terms of the plan in each classification of benefits. In addition to requiring parity across classifications, the Rule also specifies that parity must be achieved for each “level” (magnitude) for each requirement or limitation and across “coverage units” such as individual, family, or individual plus spouse.

Limitations, Prohibitions, and Exemptions

The MHPAEA and its Rule define cumulative financial requirements and cumulative treatment limitations as ones that apply across covered expenses associated with multiple episodes of care and that determine whether, and to what extent, benefits are provided. The most common types of these examples are deductibles and yearly out-of-pocket maximum limits. Health plans that apply cumulative requirements or limitations, such as deductibles or limits on number of days coverage is provided for inpatient stays, must do so in a combined fashion. For example, it is no longer permissible to have a separate deductible for mental health benefits and for medical/surgical coverage; they must now be applied as a single deductible for all health plan benefits. The only exceptions to this requirement are for the annual and lifetime dollar limits on benefits. As stated in the earlier 1996 federal mental health parity law, these two limitations may be maintained separately for both mental health and substance use disorders.

The Rule also distinguishes between quantitative and nonquantitative treatment limitations, and to date has identified six nonquantitative treatment limitations used for medical management and/or cost-containment purposes that must comply with parity requirements. They are: medical management standards; formulary design for prescription drugs; standards for providers’ admission to participate in networks, including reimbursement rates; plan methods for determination of usual, customary, and reasonable amounts; exclusions or limitations on particular therapies or treatments (unless another alternative treatment is attempted as a precondition—known as first fail...
Implications of the MHPAEA for Psychologists

There are five important practice implications for psychologists and other behavioral health providers as a result of the passage of the MHPAEA. First, it eliminates a substantial portion of the disparity that occurred in the use of treatment limitations and financial requirements applied by managed-care entities to behavioral health care that were not similarly applied to medical and surgical care. At its core, the MHPAEA is a consumer-oriented managed-care reform act that fundamentally equalizes financial requirements and treatment limitations that are applied to the use of a health plan’s medical benefits across all domains of health care (medical, surgical, mental health, and substance use disorders). During the cost-containment era consumers of behavioral-health-care services were subject to more stringent financial requirements, except for a lower deductible threshold, and consumers and providers were also subject to more restrictive quantitative and non-quantitative treatment limitations than were applied to medical and surgical care. The MHPAEA is intended to eliminate such discrepancies. By prohibiting the use of more stringent care management provisions and tactics in the behavioral-health-care domain, this Act will further reduce the contentiousness that at times characterized the relationship between consumers/providers, and the behavioral health managed-care intermediary involved in the care process. While that relationship had already evolved from one of contention to a more cooperative enterprise toward the end of the cost-containment era, this Act should have the potential to change that relationship further from cooperation to partnership. However, since the MHPAEA does not apply to the individual and small group insurance markets (companies with less than 50 employees), and issues of parity for Medicare and Medicaid patients will be directly handled by policies crafted by the Center for Medical Services, it still leaves the possibility that a segment of the market will impose different financial requirements and use more restrictive treatment limitations for behavioral health care.

Second, the MHPAEA does not require that employer-sponsored and -subsidized health plans provide benefits for behavioral health care or substance use disorders as part of the benefits of a health plan. A survey conducted by the Society of Human Resource Management in 2009 revealed that 80% of employers in the United States include behavioral health benefits as part of their overall health plans (Research Works, 2009). However, some of those employers have already decided to cease providing behavioral health benefits to mitigate their concerns about the potential increase in costs associated with achieving parity and behavioral-health-care costs in general. Behavioral-healthcare providers will need to remain vigilant to the anniversary dates when a new benefit year begins to be sure behavioral health services are still covered by a client’s health plan.

Third, the MHPAEA also does not define the disorders or conditions for which mental health benefits will be provided, leaving such determinations to health plans in consultation with group health insurance purchasers. This, of course, means that providers on multiple health plan service panels will have to deal with the greater administrative complexity involved in tracking which health plans provide reimbursement for treatment of a given condition.

Fourth, consumers who primarily utilize behavioral-health-care services will find that in many cases when accessing behavioral health care in a new plan benefit year, uncompensated care will initially require more out-of-pocket payments because parity regulations require that all health plans have a single, coinsurance/deductible limit (known in the health insurance industry as an accumulator). The MHPAEA expressly prohibits the use of separate, and therefore multiple, deductibles that have been common in employer-subsidized health plans. Prior to the MHPAEA, health plans often had separate deductibles for medical/surgical care and for behavioral health and substance use disorder services; the latter two usually had a considerably lower deductible limit before a health plan subsidized the cost of care. During the cost-containment era $1,000 and higher deductibles had become common for medical care; however, most behavioral health deductibles were set lower in order to encourage utilization. As a result of parity, the coinsurance/deductible will become a shared accumulator between medical and behavioral. For many individuals who do not have general medical problems, their entire episode of behavioral health care could become an out-of-pocket expense, deterring some consumers from seeking needed behavioral health care based on financial considerations.

Finally, psychologists will need to understand the treatment limitations, financial requirements, and progress toward fulfillment of a single deductible applied to all subscribers of a given health plan, as well as the appropriate way to engage with each health plan or Accountable Care Organization (ACO) in order to understand their obligations in relation to utilization management, quality initiatives, and administrative issues such as coding, billing,
electronic health records, and requirements for care coordination. This in turn will lead to the need for providers interested in participating in the third-party reimbursement system to develop effective electronic information systems for billing and eligibility determinations and to establish an electronic health record system capable of providing information necessary to coordination of care across multiple providers and essential to quality improvement activities.

**Patient Protection and Accountable Care Act (2010)**

The PPACA is the most far-reaching federal health-care legislation to date. Its major elements and provisions have the potential to so fundamentally restructure the marketplace that by itself, when fully implemented in 2018, it would be sufficient to serve as the foundation of a new era in health care in the United States. The comprehensive scope of the PPACA will require an 8-year period for complete implementation. Through collective impact, the various elements of the PPACA are intended to accomplish the following: (a) Lead the U.S. health-care marketplace to operate more within the framework of established microeconomic marketplace principles, compatible with the theory of managed competition; (b) accomplish a more functional balance of health-care stakeholder interests and needs than existed in previous eras; (c) establish new health insurance market rules that “qualified” health plans must abide by; (d) create a new marketplace entity known as “health insurance exchanges” through which health insurance plans are bought and sold, consumers’ health plan choices are expanded, and other key provisions of health-care reform act are administered; (e) achieve universal coverage for U.S. citizens and legal residents; and (f) compel health insurance plans, as well as provider organizations, to compete on both cost containment and quality of care.

It is also important to note what the act did not do: The PPACA did not rescind the marketplace restructuring provisions of either ERISA (which allowed employers with 50 or more employees to self-insure their health plans, stimulated the use of managed care and the involvement of an intermediary in the treatment process, and introduced selective contracting with providers), or TEFRA (which introduced the prospective payment system and stimulated carve-outs), nor did it eliminate or limit the use of managed care.

For the purpose of brevity, this chapter discusses only those features of the PPACA that are permanent (i.e., not scheduled to phase out before 2018), and that contribute to restructuring some facet of the health-care marketplace. The following section examines the PPACA’s role in implementing the principles of managed competition in the marketplace, as well as how the PPACA attempts to address stakeholders’ interests, new marketplace rules and structures, and other changes that it creates.

**Managed Competition**

The reason that the PPACA is so potentially transformative is because it encompasses almost all of the principles consistent with Enthoven’s system of managed competition, and injects those principles into the U.S. health-care marketplace. Enthoven’s principles of managed competition are designed to reduce the likelihood of future market failure; guide the health-care system toward greater efficiency; maintain and improve quality of care; and achieve a better balance of stakeholder interests and dynamics. Managed competition is not a free-market approach to health care. Rather, it relies on the active presence of a “sponsor” capable of structuring and adjusting, as necessary, marketplace forces in order to promote and maintain price competition both at the health insurance plan level and at the organized delivery systems level. Managed competition also relies on increasing consumers’ cost-consciousness by imposing cost-sharing requirements (e.g., copays, coinsurance, and deductibles) associated with episodes of treatment, as a method of discouraging unnecessary utilization of health-care services.

Managed competition seeks to reward health plans that simultaneously improve quality while decreasing costs and satisfying consumers.

The PPACA more fully places the federal government in the sponsor role, with some assistance from state-based governmental entities. Through this legislation, the federal government has assumed the role of the preeminent sponsor of managed competition, and appears to be the only existing entity capable of executing the responsibilities of a sponsor, as required by managed-competition theory.

**Balancing Stakeholder Interests**

The PPACA also strives to achieve a more functional balance of the needs and interests of the four major categories of stakeholders involved in the health-care enterprise: consumers, providers, health plans, and purchasers. For consumers, it offers more secure and affordable health insurance coverage; promotes quality-of-care initiatives; and enables access to quality and member satisfaction data related to the performance of health plans and provider care organizations. The provider community benefits from
(a) the addition of millions more patients who are enrolled in health benefit plans, and (b) the administrative simplification that occurs when there is greater standardization of the benefits covered by health plans and fewer variations in cost-sharing requirements among qualified health plans. Financial incentives are also available to providers and provider organizations in order to promote the conversion to electronic health records and to improve consumers’ health status and quality of care. The health plan community also profits from an expanded market of consumers who can potentially enroll in their plans; standardization of the essential health benefits that must be included in a qualifying health plan; and the establishment of the rules for issuance and continuance of health insurance coverage for enrollees. The purchaser group benefits from a greater focus on maintaining and improving the health status of employees and beneficiaries, as well as the likely reduction in absenteeism from work. The establishment of state-based health insurance exchanges offers a mechanism for improving the buying power of purchasers, while simultaneously providing their employees or beneficiaries with a greater choice of plans. Also, it is theorized that competition among the health plans participating in the exchanges will force those plans to compete based on quality of care and integrated service delivery.

New Health Insurance Market Rules

The PPACA makes significant changes and adjustments to private health insurance coverage rules. These changes are intended to create a more price-competitive marketplace and designed to make coverage more accessible, affordable, and secure. These new marketplace rules, which are to be phased in between 2010 and 2014 for both individual and group health insurance plans, will do the following: establish the essential health benefits package that all qualified health plans must offer (as determined or revised by the Secretary of the Department of Health and Human Services of the federal government); guarantee issue and renewability of a health insurance plan to any U.S. citizen or legal resident who applies, regardless of the presence of a preexisting health condition, current health status, or past medical history; prohibit rescinding an individual’s enrollment in a health plan (unless coverage was obtained fraudulently); limit the conditions under which health insurance premium ratings may vary to age, family structure, geography, tobacco use, and the actuarial value of the coverage; extend dependent coverage to age 26; limit the length of waiting periods for health insurance coverage to no longer than 90 days; and prohibit establishing unreasonable annual or lifetime limits on the dollar value of benefits.

Create a System of Health Insurance Exchanges

The health-care marketplace for the purchase of either individual or group health insurance coverage in the United States is highly fragmented, which in turn contributes to higher annual premium costs, a bewildering array of health plan options (some of which offer inadequate coverage), insufficient information on which to make an informed choice of insurance plan, and other systemic problems that make it difficult to contain costs and prevent market failure. The PPACA attempts to remedy this situation by creating a system of state-based health insurance exchanges through which health insurance can be bought and sold. If a given state establishes more than a single exchange for their citizens, each exchange must serve a distinct geographic area. States can choose to create exchanges that simply perform a connector function of linking eligible persons to their stated health plan preference via an Internet Web site that also provides comparative information about qualified health plans’ performance on a number of dimensions. Alternatively, exchanges could function as purchasing alliances in which they, on behalf of groups of potential enrollees, enroll people in their designated health plan, and negotiate premium rates with health insurance providers.

The PPACA provides funding for states to develop and establish health insurance exchanges in their state, in lieu of the federal government doing so, and assigns important marketplace functions to the exchanges. One of the most important functions of the exchanges is to perform certification and qualification determinations of health insurance plans seeking to be offered through that exchange. In order for a health insurance plan to be included among the eligible plans offered by an exchange, it must meet a number of federal requirements established by the PPACA concerning insurance coverage of all the “essential health benefits” in the uniform benefits package, marketing features, and use of established formats for providing information to consumers of health plans, as established by the Secretary of the Department of Health and Human Services. Health insurance plans must also demonstrate that their provider associations, networks, and quality improvement programs meet the standards set forth in the PPACA. A second important function of exchanges is to increase consumers’ choices for health insurance coverage and to make it easier for consumers to compare the benefit structure, cost-sharing requirements, and performance
on quality indicators of available health plans. To do so, each certified health plan must offer multiple coverage plans, each of which offer the same essential health benefits coverage, but differ by the percentage of health-care costs paid by the plan. (For example, bronze plans cover 60% of the health-care costs; silver, 70%; gold, 80%; and platinum, 90%.) Plans must also offer a catastrophic coverage plan for those who are exempt from the mandate to purchase health insurance or who are under 31 years old.

To help consumers make an informed choice among the many health insurance plans offered through an exchange, comparative information on a plan’s administrative performance and measures of quality performance is to be made available. A third important activity of exchanges is to conduct determinations of an individual’s eligibility for an exemption from the individual mandate to purchase health insurance, entitlement to health plan subsidies, and eligibility to participate in a public health-care program.

**Universal Coverage**

While the PPACA is focused on changing the dynamics and structure of the health-care marketplace (as opposed to changing the way health services are delivered), it is still likely to have an impact on the services that health plans offer to consumers, as the system moves closer and closer to universal coverage. When completely in force, the PPACA will have extended health insurance coverage, or access to participation in government-based health-care programs, to an estimated 32 million people (Doherty, 2010). All U.S. citizens and legal residents are required to obtain health-care coverage, except for those who exercise one of the limited exemptions from the mandate to have coverage. With the addition of these new enrollees to those already with health-care coverage, the U.S. health-care system will have virtually achieved universal coverage for its citizens and legal residents. Universal coverage will decrease the number of people who rely exclusively on hospital-based emergency medical facilities to provide their health-care services, thereby reducing the usage of the most costly form of care. With universal coverage, everyone contributes to the cost of the health-care services they receive; therefore, there is less shifting of costs from one sector of the population to another. People without health-care coverage often, out of financial exigency, delay seeking health-care services or filling prescriptions for needed medication, thereby contributing to deterioration in health status, development of medical complications, flare-ups of chronic health conditions, and even the spread of communicable diseases—all of which add to the total expenditures on health care in the United States.

Health-care systems that have achieved universal coverage also typically have a greater focus on the maintenance and improvement of overall health status, resulting in a better balance between providing preventive services versus more exclusive reliance on treatment of episodes of illness. To prepare the U.S. health-care system to engage more fully in the provision of prevention services, the PPACA provides a system of grants and eliminates cost-sharing requirements for consumers who use evidence-based prevention services.

**Systemic Implications of the PPACA**

At this time it remains difficult to determine what parts of the PPACA will be implemented; however, it is clear the health-care system is changing rapidly and will continue to evolve. In particular, three trends will continue to have an important impact on the health-care system: First, there will be a continued growth of the public sector portion of the health-care system and a subsequent decline in the employer-sponsored part of the system. Medicare and Medicaid will serve the majority of the population by 2015. Medicare will continue to grow as the Baby Boomer generation (i.e., those born between 1946 and 1964) becomes eligible for coverage. The initial migration of this population into Medicare began on January 1, 2011. There are approximately 76 million Baby Boomers, and the vast majority of them will survive to become eligible for Medicare coverage. The life expectancy of these individuals is also expected to be longer than previous generations. Such a large number of beneficiaries will strain the Medicare system, from both a financial perspective as well as a delivery system perspective.

An additional 14 million individuals will become eligible for Medicaid by 2014. The majority of individuals who do not currently have health insurance will receive their coverage from Medicaid. Similar dynamics will play out in Medicaid as in Medicare. There is not enough capacity in the Medicaid system to provide treatment for the large number of new beneficiaries. Both the Medicare and Medicaid systems will need more providers to deliver services to their increased membership. The significant growth in the population of people who have health-care benefits will require changes in service delivery systems for all markets.

Second, accountability for patient outcomes will become a major theme and force for change. As a result of both the PPACA and market forces, there will be a push for greater vertical integration of the health-care system. Integration will take the form of partnerships or organizations that span multiple disciplines as well as different
levels of care. The marketplace fragmentation represented by small health-care practices creates waste and contributes to substandard care coordination for patients. The primary service models being implemented to address quality, efficiency, and improvement in care coordination are patient-centered medical homes (PCMHs) and Accountable Care Organizations (ACOs). Both of these models for providing patient care represent a movement toward multidisciplinary integration of providers into systems that provide improved care and reduce waste. This vertical integration links outpatient providers with hospital systems, as well as other health service organizations (rehabilitation clinics, etc.). The move toward vertical integration is driven by the need for cost reduction and increased effectiveness. New capabilities are being developed to facilitate the effectiveness of vertically integrated systems. Several companies are working on information technology systems that improve their ability to identify and stratify enrollees in their health plans who have identifiable gaps in their care. Such technological advancements will help providers focus efforts on the highest-risk and highest-cost individuals, to improve health-care outcomes and to reduce costs. Application of these technological capabilities will allow for greater integrating of electronic health records (EHRs) created by providers utilizing different EHR formats to form a single view of a consumer.

Third, the PPACA addresses a number of issues that could contribute to system failure, yet leaves some important sources of health-care inflation unconstrained. As of September 2010, an estimated 16.7% of Americans—almost 50 million people—were uninsured and often utilized more expensive forms of care such as receiving treatment in an emergency department of a hospital (Schmidt, Shelley, & Bardes, 2010). The PPACA creates a mechanism for providing health care to the vast majority of those currently uninsured. In addition, it provides regulations to manage health plans by setting rules for the proportion of revenue that they must dedicate to paying medical claims. In doing so, it in essence sets limits on administrative fees and profits for health plans. In return, health plans receive a larger population to manage, with the potential to increase their gross revenue. As a result of a number of political pressures, several key problems that cause inflation in health-care premiums were not addressed by the PPACA. The Act does not propose to limit hospital fees or prescription medication costs, and it does not put limits on the cost of new technologies that are introduced in the health-care system. The lack of limits in these areas will produce vulnerability in the federal government’s ability to provide adequate sponsorship to prevent system failure without additional legislation that constrains marketplace behavior of the above.

The federal government has done a more adequate job in managing Medicare by setting pricing standards for prescription medications, hospital fees, and limits on the introduction of new technologies. The federal mandated regulations for Medicare are an example of more aggressive management for a critical part of the health-care system. In the future, many of the management techniques in Medicare may be considered for managing Medicaid and ultimately commercial health care.

IMPLICATIONS FOR THE FUTURE

It is important to understand the dynamics in place today among the various stakeholders as they struggle for position in the sponsored-competition era.

Inter-stakeholder Boundaries and Functions Are Fluid

In the FFS era, stakeholder functions were carefully defined and stakeholders were confined to their assigned role in the health-care system. However, both the cost-containment era and the current sponsored-competition era allow stakeholders to perform multiple functions, including those of other stakeholders. Purchasers can directly contract with provider health-care organizations; health plans can form their own provider organizations and can be involved in service delivery; and purchasers can assume insurance functions through self-insurance arrangements. The health-care marketplace has been gradually adjusting to these shifting stakeholder roles; however, until stable and predictable patterns emerge, all stakeholders will be caught in a cycle of perpetual change and adjustment. Stakeholders will continue to vie for position in the health-care marketplace by attempting to reduce intra-stakeholder fragmentation, thereby increasing their leverage.

Provider Functions Are Capable of Migrating Among Levels and Types of Providers, if Unimpeded by Artificial Marketplace Barriers

The health-care marketplace stands to benefit considerably from the natural migration of function that occurs in self-regulatory markets. However, powerful restrictions exist in the health-care marketplace that prevent or severely limit migration of function among health-care providers. The FFS era, with its guild-like protection of physician prerogatives, resulted in a health-care system built on
elevated physician authority and backed up by scope-of-practice laws resistant to function migration to non-physician providers. Migration of function in this instance means that the function shifts primarily to another level of provider or expands to include a broader community of providers. Battles will necessarily occur as other types of providers (e.g., nurse practitioners, physician assistants, psychologists, etc.) seek to remove barriers to assuming some of the functions of physicians. Nowhere will there be greater conflict than in the behavioral-health-care arena, as psychologists press for prescription drug privileges and access to a broader range of Current Procedural Terminology (CPT) codes.

**Cost-Containment Strategies Change in Response to Perceived Effectiveness, Consumer Response, and Stakeholder Reactions**

During the first 20 years of the cost-containment era, strategies employed by health plans to reduce expenditures underwent changes in response to their perceived effectiveness and feedback from consumers and providers. For example, as health plan personnel gathered data about the cost effectiveness of various types of quantitative and non-quantitative treatment limitations, they adjusted their use of those limitations based on outcomes. When consumers clamored for more choice of providers, health plans eventually accommodated by broadening their health plan options and networks. In general, as the cost-containment era unfolded, the use of restrictive treatment limitations was gradually replaced by more flexible engagement with providers. It can be anticipated that during the sponsored-competition era, the relationship of health plan personnel and providers will further evolve to one of cooperation and even partnership. Given that cost-containment mechanisms will be continuously evolving, it will be important for providers to keep abreast of the changes to position themselves to be viable in the marketplace.

**Future Trends and Practice Implications for Psychologists**

It is difficult to forecast the future directions of the health-care marketplace when the managing entity, in this case the U.S. Congress, is not of one mind about how the health-care enterprise should be structured and managed; health-care expenditures in key segments of the marketplace are not constrained (for example, pharmaceutical costs); and the effects of rapid consolidation among key stakeholder groups, particularly the provider and health plan communities, is underway and its impact on marketplace performance is uncertain. Notwithstanding these cautions, there are several future trends that can be forecast and implications for psychologists that can be made with a reasonable degree of certainty. The three key future trends are: greater integration of behavioral health care with the rest of the health-care system, growing importance of efforts to help patients manage chronic diseases, and increasing use of telehealth for service delivery.

**Greater Integration of Behavioral Health Care With the Rest of the Health-Care System (Co-Location of Behavioral Health)**

Although for the past two decades voices have been raised in favor of greater integration, including the co-location of behavioral health care within the medical- and surgical-care system, only modest movement in that direction has occurred to date. The comorbidity of medical and psychiatric disorders is well documented, and there is ample scientific support for the usefulness of behavioral medicine practices in medical clinics and hospitals (Chiles, Lambert, & Hatch, 1999). Co-location in health-care systems in which behavioral health care is vertically and horizontally integrated into the larger medical, surgical and rehabilitative care systems offers the promise of improving treatment quality and efficiency for complex and chronic health conditions, many of which are comorbid with mental health disorders. Integrated systems of care provide opportunities for better care coordination, simplify patients’ ability to navigate among various health-care providers involved in their care, and increase the likelihood that behavioral health conditions associated with medical illnesses will be alleviated, enabling patients to make greater progress toward diminishing the impact of persistent medical disorders. A co-location model offers many potential benefits to patients and could also create savings in overall medical costs. The most appropriate placement for mental health practice in a care delivery system is with primary care (Haley et al., 1998). It is well documented that medical patients often are influenced by psychological problems, and there is significant scientific support for the usefulness of behavioral medicine practices in medical clinics and hospitals (Chiles, Lambert, & Hatch, 1999). The placement of behavioral health care within medical clinics has the potential to increase quality and contain costs.

**Growing Importance of Efforts to Help Patients Manage Chronic Diseases Through Care Management Programs**

Care management programs are comprehensive strategies that connect a range of interventions to a larger change...
model designed to treat and improve the health status of high-need patients and those with unremitting health conditions. Typically, these programs contain elements that help reduce or eliminate barriers to coordination of care across providers; employ evidence-based clinical treatments where established, stay involved with participants throughout their illness (not just when flare-ups occur), and represent collaborative care efforts requiring active and willing participants.

There are several reasons why care management programs have become increasingly important. In the years to come, the aging population of Baby Boomers and the obesity epidemic means that more people will be battling with chronic health conditions. Because the cost of care for these groups will be substantially higher than for other health plan enrollees, either disease-specific management programs or disease management programs that focus on symptoms and self-management dilemmas common to people with persistent health conditions will be developed as a way of improving quality of life and reducing healthcare expenditures. Provisions of the PPACA that relate to insurance reform, establishment of a benefit structure that covers all essential health needs, and the way health exchanges function means that health plans and ACOs will not be able to avoid enrolling people with chronic conditions through risk-avoidance practices, benefit design, or network coverage gap strategies. Thus, they will have a greater incentive to learn how to care effectively for people with chronic health conditions. During the cost-containment era, health plans and provider-operated organized service delivery systems learned a significant amount about what is necessary to build and implement care and disease management programs, even though much remains to be done in enlisting and then successfully engaging beneficiaries in those programs. Substantial progress has been made with regard to the following elements essential to care management efforts. First, information technology systems fundamental to gathering data about potential participants’ health needs are more sophisticated and enable health plans and ACOs to identify subscribers who could benefit from such programs and to stratify and target interventions according to the level and type of involvement necessary. Second, the greater prevalence of electronic health records enables better communication across multiple providers involved in management of complex health conditions. Finally, progress has been made in establishing evidence-based treatments for more medical and behavioral health conditions.

Psychologists should be well positioned to help develop, administer, and provide care management services—and not only in the behavioral-health-care sector. The skills of the psychologist in program design and evaluation are essential elements of all care management programs. Sophisticated change models, which will be at the heart of each program, require knowledge about how to match the program design to people’s readiness to change, motivate people to participate, change their relationship with their disease, sequence and pace the elements of a change process, and use peer and group reinforcement for change. Also, because care management programs are broad in scale, involving multiple providers in multiple settings, it is necessary to develop the proper organizational structure and climate for their implementation. The skills that some psychologists have in program evaluation, organizational intervention, and executive coaching could prove invaluable for successful implementation of care management programs.

**Increasing Use of Telehealth for Service Delivery**

The Internet has the possibility of revolutionizing various parts of the health-care marketplace. Consumers have easy access to a broad range of information, from information about symptoms to descriptions of evidence-based treatments. Thus, informed consumers can evaluate their treatment against established benchmarks. As audiovisual transmission improves and becomes increasingly available to more U.S. citizens, it will have a significant impact on behavioral health care. Because most of the functions that are needed to conduct an assessment and treatment of a behavioral health patient are available through the use of interactive video, access to treatment will change significantly. The physical location of the provider or patient will no longer be the determining factor in the ability to deliver health-care services. Consumers living in remote or lightly populated areas will access care via the telehealth capacities of health plans and ACOs, thus providing them with better access to previously unavailable specialists.

**Implications for Psychologists**

There are several implications for the type of involvement, scope of practice, and nature of the way that psychologists deliver health care in this ever-changing health-care marketplace that can be forecast with a high degree of certainty. The implications stem from an understanding that health plans are the entities that administer and manage benefits that purchasers have agreed to provide for their beneficiaries, and do so by contracting with providers or operating provider organizations that deliver or coordinate
health-care services. Since the advent of the PPACA, health plans are now the segment of the health-care marketplace where health-care expenses are most controlled (i.e., at least 80 to 85% of their premium dollars must be allocated to pay for medical care and quality management). Thus, the financial success of health plans will be inextricably linked to their ability to either develop or align themselves with providers or ACOs that are capable of helping them provide quality care, enable easy patient access, reduce administrative overhead, and use other methods to deliver effective patient care. During the sponsored competition era, providers and provider organizations (such as ACOs, PCMHs and independent providers who are part of a health plan’s care reimbursement system) will need to contribute value to that system of care. The following implications for psychologists flow from understanding ways they can provide value to the care systems in which they participate.

**Participate in Public Health-Care Systems**

A 2005 U.S. Census Bureau report indicated there were 46.6 million people in the United States without health insurance coverage (U.S. Census Bureau, 2006). The PPACA relaxes participation standards and opens access to Medicaid programs for a significant number of those who have been uninsured.

With the aging Baby Boomer population, Medicare will also grow substantially during this decade. This means that the greatest growth in health plans will occur in these programs. Unfortunately, psychologists have been largely absent from participation in Medicare relative to other types of behavioral health-care providers. Participation in Medicare and Medicaid will become an important factor in joining ACOs and other provider groups, which will have contracts to provide care to beneficiaries of those programs, and will want to make sure that their providers are willing to treat patients enrolled in them.

**Increase Knowledge Regarding Working Within Medically Dominated Systems**

As the behavioral health-care enterprise becomes more and more integrated with medical and surgical care systems, understanding how they function with regard to peer review, quality assurance, and care coordination and consultation becomes important to a psychologist’s success.

Developing an awareness of the medical specialists that are commonly involved in treating conditions with high indices of comorbidity with behavioral health disorders will aid in care coordination and in identifying gaps in the care patients are receiving.

**Focus on Creating Value**

Health plans, ACOs, and other organized care systems will be focused on how each provider contributes to their success by adding value to the overall organization. In order to demonstrate that they are delivering value, psychologists will need to gather performance data regarding access, patient satisfaction, and treatment outcomes. Such data will enable health plans to help guide the psychologist’s practice development and, if performance is below standards, to sever the relationship between the health plan and the psychologist. Given the oversupply of behavioral health-care providers, it behooves the psychologist to demonstrate his or her value relative to other types of behavioral health providers. Additionally, it is likely that health plans will reward high-performing providers via a system of performance incentives.

**Become Members of Multidisciplinary Collaborative Care Teams Focused on Primary Care**

In the United States, the majority of behavioral health care is provided by primary care physicians. Because of that, it is critical that psychologists have a working relationship or an on-site presence at the locations where members access their primary care, and that psychologists participate in collaborative care planning sessions, so that patients accessing care in a primary care setting have behavioral treatment options considered as part of their treatment plan (Haley et al., 1998; Strosahl & Robinson, 2008). Psychologists should become familiar with models of collaborative care, such as Doherty, McDaniel, and Baird’s (1996) model that elucidates five levels of collaboration and integration with primary care systems in order to determine the level of collaborative care appropriate to their client’s needs.

**Contribute to the Effective Care Management of Patients With High-Need, Complex, and Chronic Health-Care Conditions**

Health plans understand that about 20% of the members of their plans account for around 80% of the medical costs incurred in treating patients in a given benefit year, and that fragmented, poorly coordinated, and unnecessary gaps in care result in high cost and poor medical outcomes. Providers who coordinate well with other providers and who can help patients navigate through the health-care system to get the care they need in a timely fashion will add value to their organizations. Also, there will be a substantial need for psychologists who are competent in applying behavioral treatments for individuals with high needs and complex cases.
Automate the Practice Setting

Electronic health records (EHRs) are vital to the efforts to contain costs and improve patients’ health outcomes. EHRs reduce the costs associated with record management, such as filing, signing, and retrieving charts, chart reviews, and the need for multiple providers to view a health record simultaneously. EHRs aid in the quality of care by having built-in features, such as treatment protocols and pop-up care reminders. Also, they are essential for facilitating care management across multiple providers involved in an episode of care, and to help health plans and ACOs identify deficiencies in care that could diminish chances for recovery or contribute to relapse.

Psychologists will need to develop Web sites that go beyond simply describing their practices. A Web site should be able to serve as a patient portal in which interactive forms of patient education and communication can take place. It should be able to help deal with access and scheduling issues, as well as other ways to facilitate patient treatment. In addition, it should have a secure feature that allows providers to share information regarding coordination of care and that enables the psychologist to gather data regarding patient satisfaction.

Finally, electronic automation should have a patient billing and claims management component that makes it easy for the psychologist to coordinate the patient’s care with other providers and to determine what additional treatment is desirable.

CONCLUSION

The United States is entering a new era in which the federal government is taking a more active role as a sponsor of a managed-competition process. However, given that the federal government is not of a single mind about how and what should be carefully managed, and that it utilizes legislative powers to inject change into the marketplace, instability, uncertainty, and tension will be everyday companions of the health-care marketplace. For example, there is speculation that some or all of the provisions of the 2010 Patient Protection and Affordable Care Act could be declared unconstitutional or repealed. Also, there is significant risk in the implementation of the new law and the related political controversy that could arise should it be upheld.

The proposed increase in enrollment to Medicaid has caused many states to raise objections to the increased costs that they will have to assume. The assumption of new enrollees will also have a cascading impact on the traditional Medicaid delivery system, which has no additional capacity. In addition, the establishment of health insurance exchanges will also add a level of complexity and cost, which states will find difficult to absorb during budget years. The combination of these issues has led to significant objections from many state leaders, as well as a new round of negotiations to alter the current PPACA legislation.

The PPACA has been characterized as an insurance reform bill that extends coverage to many Americans, but does not do an adequate job of containing costs. More actions will need to be taken by sponsors in order to contain pharmaceutical, hospital, and medical technology costs and to achieve a sustainable system. Sustainability will be achieved when coverage is available for all, and when the delivery system produces high-quality outcomes at a reasonable price. Significant restructuring of the current system and new provider payment methodologies will have to be implemented in order to achieve sustainability.

Technological advancements have and will continue to accelerate change and to restructure how care is delivered. The rapid adoption of electronic health records (more than 50% of physicians already use them) and the capability of current information technology to connect providers using different information platforms or systems will achieve a level of integration and collaboration that was not possible a few years ago. Improved methods to identify patients at risk and gaps in care of patients with identified chronic conditions will lead to more timely interventions, increased quality, and reduced cost.

Innovations such as ACOs, patient-centered medical homes, and technological advancements are already creating change in the marketplace. Such innovations will increase competition among health plans and provider care organizations, and in the long run will contribute to improved sustainability of marketplace reforms and the quality of care that patients receive.

REFERENCES


584 Professional Issues


