

Characteristics of Managed Behavioral Health Care Organizations in 1996

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Objective: Data from a survey of managed behavioral health care organizations were analyzed to describe characteristics of these firms as well as service utilization and revenues. **Methods:** Six managed behavioral health care organizations fully completed a survey by the American Managed Behavioral Healthcare Association in which they reported 1996 data for their contracts. The contracts represented more than 16 million covered lives and accounted for approximately 13 percent of all individuals enrolled in managed behavioral health care organizations in 1996. **Results:** More than three-quarters of the contracts (77.5 percent) were nonrisk. Plans described as network-based risk contracts, which represented 28.7 percent of covered members, accounted for 71.1 percent of revenues. The vast majority of reported contracts were with private employers or health maintenance organizations (HMOs); these contracts accounted for 76.8 percent of reported revenues. HMOs tended to place somewhat greater restrictions on outpatient psychotherapy and outpatient medication management visits than did other types of payers; the most common limit for HMO-related contracts was 20 outpatient visits a year, compared with 50 visits a year for other payer categories. HMO contracts also required higher copayments for outpatient visits. Utilization of services differed by payer type; for example, use of inpatient services ranged from .18 percent of covered members for contracts with private employers to .90 percent of covered members for Medicaid contracts. **Conclusions:** Overall rates of service utilization were lower than those reported in other recent studies of managed behavioral health care. The survey findings provide a starting point to guide further investigation in this area. (*Psychiatric Services* 51:1422-1427, 2000).

The managed behavioral health care industry began in the mid-1980s as a reaction to increased costs resulting from the growing inclusion of mental health and substance abuse benefits in private insurance plans. As health plans, insurance companies, self-funded plans (Employer Retirement Income Security plans), and health maintenance organizations (HMOs) began to offer managed care products for

behavioral health, managed behavioral health organizations emerged to manage these benefits by setting up and administering behavioral health provider networks (1).

Enrollment in managed behavioral health care programs has grown steadily, from 78.1 million in 1992 to an estimated 124 million in 1996 (1). Of the estimated 181.4 million people with health insurance in 1996, a total of 68.4 percent were enrolled in some

type of specialty managed behavioral health organization (2). Most organizations are large for-profit companies that operate across different types of employers and geographic areas. The industry is dominated by a small number of large firms, and their networks and operations may function differently from place to place (3).

Behavioral health care services may be embedded, as are other services, in the general delivery system of a health plan, they may be provided through a distinct and separate structure, or they may be offered in a hybrid way involving elements of both approaches (4). The term managed behavioral health care encompasses a variety of programs and technological applications. Types of products include administrative services only, utilization review, employee assistance programs, integrated management, and full-risk arrangements. The role of a managed behavioral health care organization differs markedly across these products. Arrangements vary in their intensity of care management, levels of risk, and amount of revenue, ranging from the purely administrative service and provider network model at one extreme to the full-risk capitated product at the other (5).

Despite the growing enrollment in managed behavioral health care arrangements, relatively little is known about the characteristics of the organizations and the scope of services. Kihlstrom (6) acknowledged that little information about managed behavioral health care firms is available through the major associations, and because many of the firms are not traded publicly, much of the information is proprietary.

Data for Kihlstrom's study were obtained through national surveys con-

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