Panic Disorder in a Managed Care Environment

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Practitioners need to work effectively with managed care personnel to provide the best possible mental health care to patients with panic disorder. To do so, physicians must become familiar with the organization and administrative principles common to most managed care plans. Specific strategies can be used when working with managed care personnel. These strategies include using data to demonstrate that effective mental health treatment can reduce the social and economic costs of panic disorder.
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Managed care is a term used to describe a heterogeneous group of health care and reimbursement plans that have, over time, been loosely conceptualized and inconsistently implemented in the United States. Managed care plans can be thought of as syndromes rather than specific, well-defined disorders. Managed care plans are guided by a set of common principles, but the implementation of details and options within each managed care plan can be very different.

Managed care in the United States is an evolving health care concept. Although all plans share a common language, each has its own idiosyncratic dialect. The different health care providers used and the roles the health care providers play vary depending on the structure of the managed care plan. Managed care administrators negotiate contracts with many types of health care providers. These providers may be loose affiliations of primary care physicians; formal affiliations of primary care and multispecialty groups; nonprofit, integrated hospitals and outpatient clinics; for-profit organizations; or academic medical centers. Mental health care is an even more complicated negotiation because of the many types of practitioners involved in mental health services.

An evolution common to all managed care plans is the role of the primary care physician. Power has shifted from the specialist to the primary care physician who frequently is identified as the "frontline" practitioner or "gatekeeper" for the managed care plan. The gatekeeper role has increased the work, responsibility, and authority of primary care physicians. Many managed care plans ask these physicians to triage patients to appropriate specialists and, with increasing frequency, also ask them to provide health care to patients who once might have been treated by specialists.

GENESIS OF MANAGED CARE

Social issues have influenced the development of health care plans in the United States. Throughout the 18th century, physicians in the United States were not completely trusted by many persons in the general population, but by the 19th century they established a cultural authority.[1] This change resulted from scientific discovery and the development of effective medical interventions.[1] The publication in 1910 of the Flexner Report[1] had a positive influence on physician training, and this new training greatly increased the perceived merit of physicians and their position in the social and cultural hierarchy. By the mid-20th century, however, less positive results from scientific and medical technology appeared. Concurrent with the ever-increasing importance of medical technology, physicians were perceived to spend less time with patients and more time on procedures and evaluation of data.[1,2] Technology was blamed for removing the physician from the patient's bedside, and the public's high opinion of physicians declined.

Government policies and court decisions also contributed to the development of current managed care plans. By the second half of the 20th century, health care planners both inside and outside government began to look for ways to increase the efficiency of health care and decrease the cost.[3] Researchers recommended an increase in the number of general practitioners, who would serve as gatekeepers for the managed care plans and be responsible for managing initial costs.[4] Concurrently, the federal gov-

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ernment initiated and sponsored incentive programs to encourage medical schools to increase the number of primary care physicians being trained. By the 1970s, federal legislation encouraged the development of health maintenance organizations (HMOs).[2]

In 1975, in *Goldfarb v Virginia State Bar,* the United States Supreme Court ruled that the Sherman Antitrust Act and the Federal Trade Commission Act applied to the legal and medical professions.[4] This ruling encouraged competition in health care through advertising. It encouraged physician ownership and management of hospitals and diagnostic facilities. It also encouraged insurance companies to become agents who provided care, rather than agents who financed health care. This ruling discouraged health care organizations and hospitals from sharing new, expensive technologies and equipment and from collaborating on expensive community service programs because cooperation could be interpreted as collusion.[2,5] As a result of the Goldfarb decision, the American Medical Association (AMA) modified its previously published standards of medical ethics. The new standards encouraged competition and physician ownership of health care facilities.

Managed care plans have been influenced by legal decisions that determined the extent of liability for practitioners, utilization review personnel, and the plans' primary payers. In 1986, *Wickline v State of California* established guidelines for determining negligence within cost-control programs and determined physician responsibility for patients who are members of cost-control plans. The court found that plans that deny access to care bear a greater responsibility for patient outcomes than plans that disallow payment after care has been provided. The court also found that physicians who comply with decisions made by plans and do not appeal the rulings, even though they believe the decisions are not in the best interest of the patient, can be found liable for the quality of the patient's care. The Wickline decision established a precedent for third-party payers in California to be liable for denial of patient care. In addition, physicians who do not protest treatment plans imposed by a third-party payer that, in their best medical judgment, is not appropriate for the patient can still be held responsible for the treatment.[6]

The following case provides an example of the impact of the Wickline decision. Mr. Wilson was admitted to College Hospital in Los Angeles with diagnoses of anorexia nervosa, drug dependence, and major depression. His physician had developed a treatment plan that required 3 to 4 weekends of inpatient hospitalization. The third-party intermediary for the managed care plan disagreed with the physician's recommendation and refused to pay for the treatment. Mr. Wilson had financial concerns and left the hospital, despite his physician's recommendation. Within 20 days of discharge, he committed suicide. A lawsuit was filed and the court handed down the Wilson decision. In this ruling, the court held that the third-party managed care plan intermediaries could be liable for denial of care if care was denied inappropriately and contrary to the recommendation of the treating physician.[7]

Table 1. Tenets of Managed Care

Recruit healthy people into the program
Limit access to expensive technologies and therapies
Limit care by more expensive therapists
Encourage the use of the least expensive qualified professionals
Capitate to control costs to the payee

The Salley decision resulted from a lawsuit filed by a retired employee of E. I. DuPont de Nemours & Co. on behalf of his daughter who had been hospitalized because of suicidal ideation. During the daughter's third hospitalization, her psychiatrist told the third-party intermediary that the patient would deteriorate if she left the hospital without extensive outpatient care. The intermediary refused to continue to pay for the patient's hospitalization. The treating physician refused to discharge the patient until a suitable therapeutic environment was available for outpatient care. A federal court ruled that DuPont was liable for all the patient's hospital bills because the company was liable for the action or inaction of its third-party intermediary.[8]

PRINCIPLES OF MANAGED CARE PLANS

The social forces—scientific, treatment, and technological developments, federal legislation, and legal decisions—that influenced the development of health care plans in the United States continued to determine the direction and structure of managed care, including corporate "for-profit" health care plans. The public's concern about health care costs and their disenchantment with the lack of access to physicians encouraged the development of alternatives to fee-for-service care. Managed health care was initially proposed as one solution to controlling costs and increasing quality. Unfortunately, many existing managed care plans are now designed to maximize profits for the corporation responsible for administering the plan (Table 1). Administrative costs have increased nearly 100% in the last 10 years[2] because for-profit systems control costs by inserting a barrier between physicians and patients. This barrier can be a capitation program or a preauthorization requirement for using any component of the plan.

There are many ways to lower costs in a managed care plan (Table 2). Most cost-control methods discourage patients from using the plan or require extensive justification by the physician for follow-up care, laboratory procedures, and drug therapy. An internal or contracted third-party utilization review program provides a formal, structured method for controlling costs. These programs serve as "watchdogs" to oversee the costs of delivering care (Table 3).

Managed care plans were initially perceived as a method for controlling the increasing costs of medical

Table 2. Techniques Used by Managed Care Systems to Lower Costs

Limit use of services by discouraging frequent visits, maintaining long waiting lists for appointments, and making patients wait in the office for their scheduled appointments
Reduce in-person follow-up appointments and encourage telephone contacts with less expensive health care professionals
Restrict access to specialists by requiring prior authorization for visits
Require physicians to justify laboratory tests
Restrict expensive medications when developing formularies
Require extensive written justification from specialists for continuing patient care
Review referral and utilization patterns to eliminate costly gatekeepers and specialists
Use extensive utilization review procedures
Subcontract mental health care to the least expensive mental health professionals

Table 3. Techniques Used by Utilization Review Programs to Control Costs

Require preapproval for care
Require permission for continued care
Require extensive and frequent justification from health care professionals for continuing care
Just say "no" to requests for care; fewer than 10% of patients or health care professionals appeal
Discourage ongoing relationships between patients and physicians
Eliminate physicians who are "cost outliers" from panels

care. They are now often perceived as a method for increasing the profits of intermediary programs. Many of the cost-saving methods discourage patient access to the managed care plan and require extensive physician justification for patient treatment. Too often, cost evaluation determines how physicians in the plan practice medicine.

ECONOMIC BURDEN OF PANIC DISORDER

According to data from the epidemiologic catchment area (ECA) survey,[9] the lifetime prevalence for panic disorder is approximately 1.5% of the general population. The ECA survey found that 60% of the men and 68% of the women with panic disorder at the time the survey was taken were unemployed.[10] Twenty-five percent of the men and 29% of the women with panic disorder had been unemployed for the previous 5 years. Thirty-three percent of the men and 15% of the women with panic disorder received some type of disability payment.

The economic effects of panic disorder are more than disability and unemployment. Sixty-three percent of the men and 56% of the women with panic disorder sought help for emotional-, drug-, or alcohol-related problems in the 6 months before the ECA survey. Persons with panic disorder seek treatment at medical facilities seven times more frequently than the general population.[11] Those with panic disorder call in sick to work at least twice as often as the general population. Salvador-Carulla et al.[12] found that the use of general medical services decreased by 94% the year after patients with panic disorder were correctly diagnosed. In this study,[12] 29 persons with panic disorder had a decrease in total sick days from 1050 to 190 in the year after their diagnosis.

TREATMENT OF PANIC DISORDER

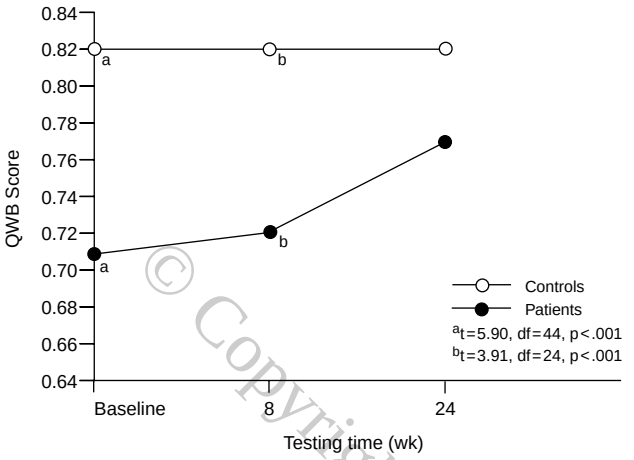
Recent data suggest that behavioral and pharmacologic treatments for panic disorder are effective and appear to have long-lived, positive health benefits. In one study,[13] 81 patients with panic disorder and agoraphobia who became panic free after 12 half-hour sessions of individual behavior therapy had remission rates of 96% at a 2-year follow-up, 77.6% at a 5-year follow-up, and 67% at a 7-year follow-up. The researchers reported that 15 of the 81 patients relapsed during the follow-up period. Thirteen of the 15 patients responded to brief "refresher" behavior therapy (mean = four individual sessions); 12 of the 13 patients were symptom free at a 1-year follow-up. The investigators identified two factors associated with relapse: (1) presence of residual agoraphobia at the end of behavior therapy; and (2) diagnosis of a personality disorder after successful behavior therapy for panic disorder.

An increasing number of studies of patients with panic disorder who were treated with group cognitive behavior therapy indicate that symptom relief is long-lived. Brown et al.[14] found that group cognitive behavior therapy of panic disorder was effective even in patients with comorbid anxiety or major depressive disorders.

In a German systematic follow-up study,[15] 50 patients with panic disorder (30 without comorbid depression and 20 with comorbid depression) were initially treated with 8 weeks of doxepin or imipramine and then given naturalistic medical and supportive therapy for up to 8 months. The authors reported that most patients were significantly improved at the 5-year follow-up. Sixty-six percent of the patients who had panic disorder without comorbid depression and 55% of those with panic disorder and comorbid depression were medication free at follow-up. Although the group with panic disorder and comorbid depression had higher baseline and follow-up Hamilton Rating Scale for Depression (HAM-D) scores and Hamilton Rating Scale for Anxiety (HAM-A) scores, there was no difference in the degree of impairment from panic symptoms for the two cohorts at follow-up.[15] These findings suggest that even patients with complicated clinical presentations respond well and exhibit some lasting symptom relief to existing treatments for panic disorder.

Our group recently completed a study of the effectiveness of cognitive behavior therapy plus extended-release alprazolam versus cognitive behavior therapy plus placebo for panic disorder. We used a well-described measure of social functioning, the Quality of Well-Being (QWB)

Figure 1. Scores on the Quality of Well-Being (QWB) Scale for Patients With Panic Disorder Before, During, and After Treatment With Cognitive Behavior Therapy Compared With QWB Scores for Healthy Control Subjects Matched for Age, Sex, and Education



scale, to assess the social and work-related functioning of our patients.[16] The QWB scale has been validated in many medical disorders, including diabetes, hypertension, and human immunodeficiency virus infection. We found that patients with panic disorder and mild-to-moderate agoraphobia had a significant loss of quality-adjusted life-years, similar to that reported for patients with noninsulin-dependent diabetes mellitus.[17] Preliminary data also demonstrated a restoration of quality-adjusted life-years 3 months after therapy was discontinued (Figure 1).

Panic disorder is associated with a significant decrease in quality of life. Patients with undiagnosed panic disorder make frequent use of health care plans. Those with untreated panic disorder suffer significant disability, use more sick leave, and have a diminished quality of life. The results of treatment studies suggest that current therapies are effective and that their effectiveness is long-lived. Preliminary data also suggest that treatment relieves symptoms and restores quality of life.

STRATEGIES TO "MANAGE" MANAGED CARE

The considerable number of different managed care plans and the justification required for patient treatment plans are problems for psychiatrists and mental health professionals. A physician or other health care professional who contracts with a managed care plan must know the benefit plan structure. Is the plan capitated? Does the plan have a mental health "carve out"? Are the mental health benefits well defined? Who is the gatekeeper for the mental health portion of the plan? What are the qualifications of the utilization review personnel? What are the criteria for evaluating treatments?

Table 4. Strategies for Influencing Managed Care Plans

Personally meet with other health care professionals in the plan
Establish your expertise as a consultant and specialist for the plan
Educate members as to how psychiatric care can lower costs for the plan
Provide quantifiable and objective data in your notes
Propose or develop cost-effective, defined treatment algorithms for patient care

Mental health professionals should also know the personnel who administer and those who participate in the managed care plan. Whenever possible, they should meet and establish a professional relationship with the primary care providers or gatekeepers, administrators, and utilization review personnel. Personal contacts may facilitate patient referrals, provide an opportunity to influence future decisions on plan benefits, and decrease the possibility that patient services will be disallowed.

The goal is to mandate to practitioners. To achieve this goal, mental health professionals should increase their visibility within the system by becoming educators for the plan administrators, corporate sponsors, gatekeepers, nonphysician mental health professionals, and patients (Table 4). They should share with plan administrators and, when possible, with corporate sponsors the economic and social cost data about panic disorder. They should discuss the emerging literature that demonstrates how effective treatment can decrease patient use of medical services and increase patient satisfaction and quality of life. Mental health professionals must be active consultants with gatekeepers for the pharmacologic management of patients with panic and other psychiatric disorders. They must teach gatekeepers how to use objective rating measures to monitor the effectiveness of their interventions.

Educational effort will establish and maintain referrals, credibility, and good professional relationships with gatekeepers. Effort should also be directed to nonphysician mental health professionals for both diagnostic- and treatment-related issues and to ensure referrals. Patients should be educated about the benefits of treatment, including both relief of symptoms and improved quality of life. These are the most important roles mental health professionals can play in a managed care plan.

CONCLUSION

Psychiatrists and mental health professionals who understand the cost and social morbidity data related to panic disorder, as well as how to effectively treat panic disorder, can work more efficiently within managed care systems. The published treatment data for patients with panic disorder make a compelling case that effective treatment of panic disorder can decrease costs for the managed care

plan and the patient's employer and increase the patient's quality of life. With knowledge and hard work, the clinician can effectively "manage" managed care, even as it continues to change in the future.

Drug names: alprazolam (Xanax), doxepin (Sinequan and others), imipramine (Tofranil and others).

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Discussion

Managed Care

Dr. Rosenbaum: If you were designing a managed care protocol for treating panic disorder, what essential elements would you include?

Dr. Rapaport: The least expensive aspect of treatment is education, for both patients and their family members or caregivers. Education about panic disorder, its course, prognosis, and treatment interventions can help patients and family members develop a sense of control and will facilitate treatment gains between therapy visits.

Dr. Ballenger: Another factor to consider is the overall cost of treatment versus the cost of an individual drug. A serotonin selective reuptake inhibitor costs twice as much as a tricyclic antidepressant, but the overall cost of treatment is lower because compliance is higher and the need to switch to a second drug is lower.

Dr. Rosenbaum: With the serotonin selective reuptake inhibitor, compared with tricyclic antidepressants, you do not have the high cost of treatment failure or treatment discontinuation. You also do not have the costs associated with extra visits for titration, electrocardiograms, plasma level monitoring, or side effects.

Dr. Marshall: The total cost of treatment is the critical issue.

Dr. Rapaport: If you can identify the high-utilizing patients with anxiety disorders and treat them, in theory, you can decrease the overall cost of care. This was clearly demonstrated in the study by Salvador-Carulla and colleagues.

Dr. Jefferson: The problem is that the savings are in the wrong person's pocket. As a result, we need to be moving toward employers contracting directly with large provider groups and cutting out the managed care organization. In that context, the *employer* probably can save money even if a patient's depression or panic disorder is recognized and treated.

Dr. Rapaport: We need to have several different strategies in place. One is for the situation just described, in which employers contract directly with caregivers. Another strategy is to educate the primary care physicians—the gatekeepers—in a managed care organization, saying "One of the things that may help you is to consider the presence of depression or panic disorder in your high-utilizing patients." If you raise the index of suspicion, patients might be more effectively treated and costs lowered.

Dr. Charney: We work with a staff model health maintenance organization, which makes education of the primary care physician much easier. I have been working with the same physician for 10 years, so my educational efforts have begun to have an impact. These physicians can reasonably make a diagnosis and prescribe effective medication. However, they are not typical of primary care physicians; it depends on how the managed care company is organized.

Dr. Jefferson: Given the diversity of health care plans, I do not know if we can come up with one strategy for

managed care. Yet, all plans are concerned with cost saving and cost effectiveness. Thus, our goal should be to educate the managed care administrators about effective treatments that are easily administered, such as high-potency benzodiazepines and targeted, time-limited psychotherapies. We take these interventions for granted because we are so familiar with them, yet, in the "real world," most physicians and administrators are not aware of them. We need to get the message out that these are cost-effective approaches to treating a patient with panic disorder. Although hard data are not yet available to prove these interventions save money, they have an advantage over other treatments in terms of established efficacy.

Dr. Rosenbaum: It may be that the people we need to influence are the employers who purchase health care insurance for employees. Employers need to be convinced that they lose a lot more from lost work days and decreased productivity from employees who are ill or those who have family members who are ill.

Dr. Davidson: Along those same lines, benefits managers need to understand they are costing themselves money by buying what appears to be less expensive care. Although a tricyclic antidepressant costs less than a serotonin selective reuptake inhibitor, it may cost more in the long run, because of the net cost to the company in lost productivity and employee quality of life.

Dr. Jefferson: A trend in managed care is to use the least extensively trained provider. Patients with psychiatric disorders often are referred initially to social workers or counselors with master's degree training. Patients typically are not referred to therapists with doctoral-level degrees who are in the best position to make the right diagnosis and ensure that the right treatments are implemented. This seems particularly true with an illness such as panic disorder. Yet the managed care company is wasting money unless the patient is referred first to a clinician with the highest level of training, such as a psychiatrist or psychologist.

Dr. Ballenger: Limited data are available in patients with depression, showing that it is less expensive and the patients receive better treatment if they are referred to a psychiatrist rather than being treated by a primary care physician.

Dr. Shear: Although there is no proof, we can assume that patients will not receive pharmacologic or cognitive behavior therapy from social workers, because they are not trained in these areas. Patients will receive a longitudinal supportive relationship. While there is no evidence that this approach is not effective, it is highly unlikely to produce efficacy findings comparable to proven treatments.

Dr. Rosenbaum: A question to consider is, What is good enough and what is optimal? For example, medication alone provides fairly good results, although not as good as combined treatment with drugs and behavior therapy. Should payers be required to pay for sufficient treatment so that patients are not just better but as well as they can be?