

The
Clinician's
Guide *to*
Managed
Behavioral
Care

Second Edition of
*The Clinician's Guide to
Managed Mental Health Care*

Norman Winegar

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The Clinician's Guide to Managed Behavioral Care *Second Edition*



*Noteworthy
REVIEWS
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“**A** survival kit for practitioners in an era when managed care has taken from clinicians the control of their own practices. Those who read and learn from Mr. Winegar's book will survive and prosper. . . . The book provides the practical, basic knowledge required to understand the current revolution in health care and to respond effectively. All this is presented in a clear, concise fashion that is readily understood.”

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*Founder, American Biodyne, Inc.,
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A solid introduction to the managed care environment itself and to managed mental health care in particular. Its detailed yet concise style is highly readable without becoming overly technical for benefits managers and other health care decision-makers."

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An extremely informative guidebook to managed care for clinicians. The book has something for everyone, from the practitioner already employed in managed care settings to independent clinicians in areas where managed care is only beginning to impact their work with clients. . . . Winegar has done an exceptional job of clearly explaining how and why managed mental health care systems work as they do."

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Jaclyn Miller, PhD, LCSW
*Director of Field Instruction,
Virginia Commonwealth University*

Helps readers see their role more comprehensively in relation to others in a managed care system. I especially like the clear guidelines for adding managed care functions to employee assistance programs, for influencing the utilization management process, for informing client/consumers of their choices, and for surviving in an era of managed care."

Joseph R. Steiner, PhD, ACSW
*Professor and Chair,
Occupational Social Work,
Syracuse University*



An invaluable resource for anyone in today's health care field. Winegar provides greatly needed insight into managed health care operations and values. . . . I recommend this book to clinicians, human resource managers, and anyone interested in the expanding role of managed mental health care."

Margaret Kellogg, MSW
*Licensed Clinical Social Worker
in Private Practice,
Johnson City, Tennessee*

More noteworthy
REVIEWS OF THE FIRST EDITION

“Easily the best explication of managed care principles and practices as they are developing in the mental health arena. . . . an excellent resource, one that is desperately needed by independent practitioners who have not had the opportunity to sort out and grasp the complexities of emerging managed care systems. . . . Perhaps the greatest contribution Winegar has made resides in his clear explanation, using detailed examples, of exactly how these systems work.”

Larry K. Hill, EdD
*Licensed Professional Counselor
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**The Clinician's Guide
to Managed
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Norman Winegar

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Acknowledgments

This book is aimed at providing counseling professionals and others interested in the delivery of mental health care services to Americans an overview of managed behavioral care systems and strategies. It is hoped this book will contribute in some small way to the improvement of services received by American consumers and toward an increased partnership between the payors, providers, and utilizers of valuable mental health care resources.

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Introduction

A revolution has changed how mental health and substance abuse treatment services are delivered to most Americans. It has affected the practice of most behavioral care clinicians in both private and public sector settings. It has helped transform the private psychiatric hospital industry and has reshaped and revitalized community-based outpatient care. The revolution is Managed Behavioral Care.

Today more than any time in the past, both practicing clinicians and students anticipating a career of service in the treatment field must be knowledgeable about the current practice environment and armed with strategies needed for successful competition. This book enables the reader to understand the operations, values, and philosophies of managed care systems while discussing the strategies clinicians need for successful practice in an increasingly changing and competitive area of health care.

This competitive environment in the behavioral care field was recently highlighted by Michael A. Freeman, MD, President of the Institute for Behavioral Healthcare and founder of the *Behavioral Healthcare Tomorrow* journal.

At the current time there are approximately 250,000 licensed mental health clinicians in the United States, or approximately 1 per 1,000 Americans. By contrast, most HMO mental health programs rely upon 1 mental health clinician per 5,000-6,000 members. Most managed behavioral carve out firms, which in the past have maintained broader provider panels, are increasingly shifting referrals to behavioral group practices. What does this mean for the average clinician? As Americans continue to drift into organized systems of care, there could be a surplus of as many as 80,000-100,000 licensed mental health profession-

als across the country. The pressure on mental health clinicians who wish to stay in business will be intense.

MBC has changed traditional practice in numerous and diverse ways. Most concern increased accountability and structure. Alternative fee and pricing arrangements, the organization provider networks, the hiring of specialized clinicians and clinical managers, the development of practice standards, redesigned employee benefit plans, new models of Employee Assistance Programs, the variety of utilization management technologies and processes, and an emphasis on outpatient solution-focused treatment are only a few of MBC's change strategies.

As an emerging growth industry, MBC is frequently a source of confusion and consternation to practitioners, managers, consumers, and purchasers. At its worst, it is perceived as an intrusive, confusing impediment to or interference with clinical practice. At its best, MBC is a partnership between providers, MBC firms, and payors in providing quality, cost-effective care to consumers while ensuring that benefits for such services are preserved.

This book will enable the reader to understand the fundamentals of Managed Behavioral care operations, the market for these services, how clinicians and facilities can integrate themselves in the increasingly "managed" practice environment, and MBC trends in coming years. Appendixes provide the reader with useful supplementary information, including an up-to-date listing of the nation's over 600 HMOs as well as a directory of America's leading MBC specialty firms.

Throughout this book, the term Managed Behavioral Care, or MBC, will be used to describe these entities. These firms may provide direct services to clients, provide services indirectly through Provider Networks, or may only manage mental health and substance abuse benefits.

The term "member" is frequently used throughout as the descriptor for the individual consumer of managed care services. "Client" and "patient" are used interchangeably. The term "provider" is a generic one, referencing any practitioner or clinician rendering services.

The book aspires to contribute by providing information about

MBC systems, their impact on practice in the mental health, substance abuse, and Employee Assistance fields, and how professionals can continue to serve their clients, while prospering professionally in a time of radical change in America's mental health delivery system.

REFERENCE

Freeman, Michael A. (1994, October). (Personal Communication.)

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Chapter 1

What Is “Managed Care”?

Managed care is a term that elicits a variety of reactions from health care professionals. Some practitioners feel anxious, confused, or bewildered as they try to provide traditional care to clients while coping with a maze of acronyms, undecipherable insurance jargon and procedures, and unclear or distasteful “business” concepts that have invaded clinical practice. Others feel resentment or even anger at managed care firms—resentment toward systems that seem to constantly question their clinical judgement and autonomy, and anger toward perceived threats to their professional livelihood. Many clinicians who have fought hard for increased access to counseling and therapy services for consumers are angered by what they see as managed care’s roadblocks to individuals and families receiving such care. They point to waiting lists, “gatekeepers” (who may not be clinicians), and excessive paperwork as obstacles to treatment imposed by managed care systems in an effort to restrict or deny services.

Other groups are concerned about managed care as well. Employee assistance professionals, accustomed to directing clients to particular treatment modalities and providers, are now confronted with relinquishing that role to others when managed care systems are involved. Hospital-based treatment staffs face declining admissions, reduced lengths of treatment stays, and radical restructuring of traditional programs due to the influence of managed care. Graduate students in the counseling professions wonder whether or not their education is preparing them for the actual practice environment of the coming decade. Many students and clinicians even question if “private practice” as it has been historically defined will survive in the future. They wonder how and if their “practices” will interface with managed care systems. What new strategies, skills, and innovations will they need to employ to be successful in the era of managed care?

Meanwhile these concerns and questions take place in the larger health care environment in the 1990s—one in which insurance behemoths are purchasing their own specialty managed care/employer services companies; where unions initiate work stoppages over employer benefit issues; where the federal government is experimenting with managed care systems for its CHAMPUS members, while policymakers debate greater federal involvement in controlling health care costs; where consumers are turning to HMOs and other managed health care alternatives as the cost of traditional health insurance products escalate. Rather than wish for a return to simpler times when counseling and treatment services were purchased on a “fee-for-service” basis and client choice reigned supreme, counseling professionals and others are being challenged to learn about managed care systems and how their influence on practice will increase in the years to come. By doing so they will be better prepared to prosper in changing times while fulfilling traditional roles of service delivery and client advocacy.

ESSENTIAL FACTS

Managed care, or, as it applies more specifically to our discussions, Managed Behavioral Care, is a term applied to a variety of strategies, systems, and mechanisms that have as their objectives the monitoring and control of the utilization of mental health and substance abuse services while maintaining satisfactory levels of quality of care. MBC has as its focus the marshalling and coordinating of the appropriate clinical and financial resources necessary for each client's care. Essentially, managed care clients' needs are matched to appropriate treatment resources, and then the delivery and outcome of these resources are monitored. Managed care developed a significant presence in the 1970s and made important impacts in the mental health and substance abuse treatment fields in the 1980s. MBC will revolutionize America's mental health care delivery system during the 1990s.

There are three basic facts about managed care today:

1. *Managed care is here to stay!* It will not go away. Its impact on treatment patterns and reimbursement systems will only increase in

years to come. Managed care has already made impressive in-roads into the health care market and it continues to grow. According to industry publications, enrollment in America's 540 HMOs grew in membership to about 49 million Americans in 1993, an increase of over **10 percent** from the prior year. Almost one in five Americans are enrolled in an HMO, easily double that number are involved in some sort of employer-sponsored managed care product. HMOs were headquartered in every state except Alaska, West Virginia, Vermont, and Wyoming. A large majority of employers offer HMOs as a part of their health care benefit menu—an attractive option to many Americans. These numbers do not include the millions of consumers who are involved in other types of managed care systems, either through their employers or through insurance carriers. Nor do they reflect the several million Medicaid and other public sector consumers who are increasingly moved through managed health care systems.

Some have advocated for Federal intervention in health care in such ways that would eliminate managed care, HMO, and insurance companies in favor of a government-run health care system financed through taxes, not insurance premiums. The spectacular failure of President Clinton's health care reform legislation and the subsequent 1994 election results, together with the continued embrace of managed health care by the private and public sectors, seems to have dimmed the hopes of those who favor greater governmental administration of the health care industry. Clearly, consumers will receive care, and practitioners will continue to deliver care through managed care systems in ever increasing proportions. Managed care structures, including HMOs, are the rule not the exception.

2. *Understanding managed care systems, philosophies, and dynamics is essential for successful clinical practice in the future.* Today more than half of America's physicians conduct at least part of their practices in association with HMOs. Still others are associated with Preferred Practice Organizations (PPOs). Clearly, managed care systems have exerted tremendous influences on physicians during the last decade, and their influence will extend deeper into the allied health professions in the 1990s. Successful counseling professionals, agencies, and facilities will be those whose practice patterns and programmatic offerings are most attractive to managed care systems.

3. *Managed care is not the problem in health care today.* It is a response to the problem confronting consumers, providers, and purchasers alike: rising health care costs, especially that segment of costs associated with the mental health/substance abuse treatment field. To many employers this "grey area" of health care seems particularly in need of "management."

The nation spent over \$884 billion or about \$3,300 per person for health care in 1993 or about 13.9 percent of the Gross Domestic Product. One of the fastest growing segments of costs have been mental health and substance abuse treatment services. Employers and employees through private health insurance plans bore the largest share of these costs, while taxpayers absorbed the next largest portion of the national health care bill through Medicare, Medicaid, and other government-administered programs. Table 1-1 delineates this information further, while Figures 1-1 and 1-2 deal with 1991 data.

Because about one third of health care costs are paid by taxpayers, the rise in costs has helped to maintain the deficit in Federal spending and to place increasing burdens on state governments as well. One of the themes of President Clinton's ill-fated 1994 effort at health care system reform was that health care costs were driving government spending faster than the growth of the economy. Rather than wait for federally mandated reforms, numerous state governments have initiated waivers from regulations concerning Medicaid funds and are introducing managed care systems to the public sector at a rapid pace. Table 1-2 details federal and state/local government health care spending trends.

**BACKGROUND:
DEVELOPMENTS THAT SET THE STAGE
FOR MANAGED BEHAVIORAL CARE SYSTEMS**

Introduction of Prepaid Health Care

Three historical developments helped shape today's application of managed care to the psychiatric and substance abuse treatment fields. First was the gradual development of prepaid health care coverages. The most prominent feature of these systems was that the consumer paid one monthly fee and then received all health care services from selected providers at little or no cost.

TABLE 1-1. National Health Expenditures as a Percent of Gross Domestic Product, Selected Years

Year	% of GDP
1960	5.3%
1965	5.9%
1970	7.4%
1975	8.4%
1980	9.2%
1985	10.5%
1986	10.7%
1987	10.9%
1988	11.1%
1989	11.5%
1990	12.2%
1991	13.2%
1992	13.6%
1993	13.9%

Source: Letsch, S.W. et al. *Health Care Financing Review*, Winter 1992, Vol. 14, Number 2, and *HHS News Release: National Health Expenditures for 1993*. Nov. 22, 1994.

Even though the first rudimentary examples of prepaid health care coverage came in the first decade of this century, the major breakthrough for Health Maintenance Organizations (HMOs) occurred in the late 1930s and early 1940s. Industrialist Henry J. Kaiser and physician Sydney Garfield established the first HMOs in Oregon and California. They served the health care needs of Kaiser's employees. These organizations were very successful in the cost-conscious World War II era. From these efforts came the Kaiser-Permanente Health Maintenance Organization, the nation's largest group model HMO. (See Chapter Two for discussion of HMOs and HMO models.) Kaiser-Permanente flourished first in Northern and then Southern California. Later HMOs made their appearance in other parts of the country and were particularly successful in the Minneapolis-St. Paul area of Minnesota and in Wisconsin.

FIGURE 1-1. The Nation's Health Dollar in 1991

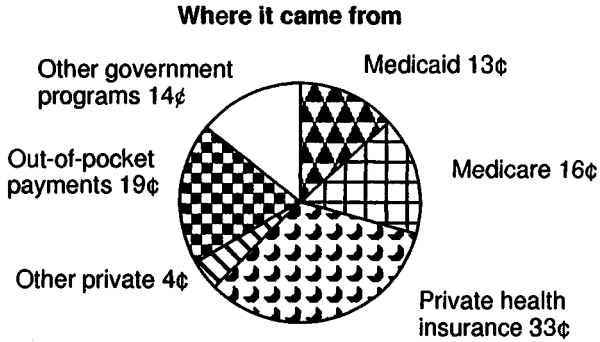
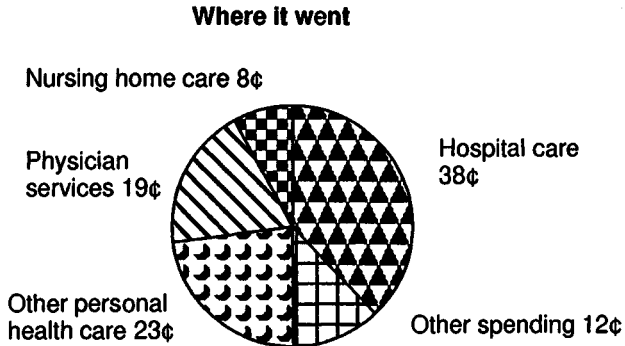


FIGURE 1-2. The Nation's Health Dollar in 1991



NOTES: "Other private" includes industrial inplant health services, non-patient revenues, and privately financed construction. "Other personal health care" includes dental, other professional services, home health care, drugs and other non-durable medical products, vision products and other durable medical products, and other miscellaneous health care services. "Other spending" covers program administration and the net cost of private health insurance, government public health, and research and construction.

SOURCE: *Health Care Financing Review*, Winter 1992, Vol. 14, No. 2.

TABLE 1-2. Government Health Spending as a Percent of Total Government Spending, Selected Years

Year	Federal Government	State/Local Government
1960	3.1	7.8
1965	3.9	7.6
1970	8.5	7.8
1975	10.0	8.5
1980	11.7	9.9
1985	12.7	10.8
1986	12.9	11.1
1987	13.5	11.6
1988	14.1	11.9
1989	14.8	12.3
1990	15.3	12.9
1991	16.7	14.1

Source: Letsch, S.W. et al., *Health Care Financing Review*, Winter 1992, Vol. 14, Number 2.

Still, by 1970 less than three million Americans in fifteen states belonged to HMOs. The label of "socialized medicine" and the opposition of physician and hospital groups had hampered their growth. It was the Nixon administration who gave impetus to HMO growth through its support of legislation that "federally qualified" an HMO and mandated its offering to employees in the geographic area it served. Called the HMO Act of 1973, this law required that employers of twenty-five employees or more must offer an HMO option, if an HMO is in operation in their locale, and if requested by the HMO to do so. During the Carter administration, Health Education and Welfare Secretary Joseph Califano simplified the HMO qualifying process and HMOs began to expand. There was a sizable jump in enrollment in the early 1980s and growth continued, though at a slower pace, in the latter part of that decade. The industry as a whole struggled financially during the 1980s as it attempted to control or slow down rising health care costs. Some, mostly smaller, poorly capitalized HMOs failed, while others were purchased or absorbed by larger organizations. By 1990 a financial turnaround

had been achieved in the industry. Analysts predict that while the number of HMOs will drop in the 1990s, there will be continued growth in membership overall. Additionally, the success of HMOs spurred the development of other managed care systems such as PPOs which compete for membership. (See Chapter 3.)

Just as the 1973 HMO Act had far-reaching effects on the development of HMOs, the 1974 Employee Retirement Income Security Act (ERISA) was to facilitate growth of managed care systems as well. Even though this act was primarily aimed at pension equity, ERISA contains a provision allowing self-insured groups to be exempt from most state regulations pertaining to mandated health insurance benefits and mandated provider requirements.

For example, until recently most HMOs charged premiums to employers and employees based on "community ratings," that is, based on the projected cost of services provided to the entire HMO membership, not a single group of employees. Under ERISA, a large employer may choose to fund insurance coverage only for its own employee population. In this way the employer hopes to take advantage of its own efforts to maintain a healthy work force. By not funding and participating in the larger pool of insurance groups, it hopes to achieve cost-savings. Self-insured employers have great flexibility in designing benefits. For self-insured employers, insurance carriers serve only to administer the program. Employers sometimes use Third-Party Administrators (TPAs) for this function, as well. During the 1980s, self-insured employers proliferated. Today, ERISA provisions continue to influence how health benefits are designed and administered. (See Chapter 7 for a further discussion of ERISA.)

Growth of Private Psychiatric Hospitals

Responding to reimbursement system changes and changes in societal attitudes, the development of private, for-profit, psychiatric and substance abuse hospitals and treatment units was a second factor in the development of managed care systems in the mental health area. These facilities grew rapidly in the late 1970s and throughout the 1980s. The development of the Diagnostic Related Groups (DRGs) as a funding mechanism for Medicare inpatient medical care indirectly helped to spur this development.

In 1975 the DRG system was developed at Yale University and included 467 diagnoses. The federal government began utilizing it for Medicare patients as a cost management tool, a means of sharing financial risk with hospitals. Under a DRG system, a schedule of maximum payments for hospital care is developed for each diagnosis. The hospital is reimbursed for this amount, regardless of the actual length of the admission. For example, if diagnosis "X" is covered for four hospital days, but the patient is well enough to be discharged after three days, the hospital is still reimbursed for four days of care. Likewise, if the patient is so ill that five days of hospital care is required, the hospital will only be reimbursed for four days.

DRGs, a form of managed care, were used for medical/surgical hospital care but were not applied to psychiatric diagnosis, due to the lack of professional consensus about treatment of various disorders. They did impact hospital management by indirectly incenting hospitals to expand into the area of mental health and substance abuse care. These hospitals and specialty units in general hospitals proliferated in the late 1970s and throughout the 1980s.

Another factor that stimulated the growth of inpatient psychiatric facilities were changes in statutes concerning the housing of minors with adults in correctional facilities. As society decided that many troubled teenagers should not be housed in existing correctional facilities, psychiatric hospitalization often became a more attractive and humane alternative (while still fulfilling much of the social control function that was desired by parents and the judicial system). Between 1982 and 1986 the percentage of adolescents as a portion of the population as a whole declined, but the incidence of hospitalization of teenagers went up 350 percent!

Thus, by the late 1980s, most larger communities had several competing inpatient-based substance abuse or adolescent treatment units providing intensive and very costly care. These hospital-based units became large employers of nonphysician counseling professionals. They marketed toward Employee Assistance Program staff who could direct referrals to them. They also formed lucrative formal or informal arrangements with psychiatrists who were expected to admit their patients to these units for the milieu treatment of the inpatient environment. Often the fees derived from inpatient care

became an important income source for psychiatrists, overshadowing their outpatient practices.

Expansion of Counseling Professions

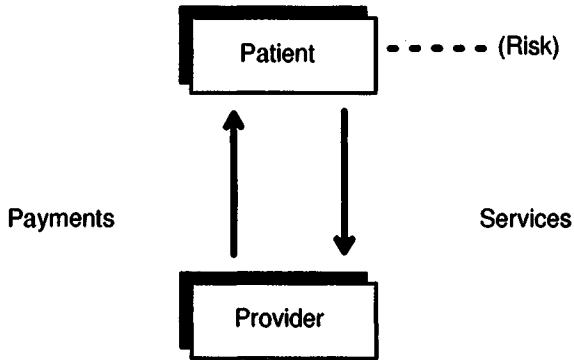
A third development, paralleling the other two, was the proliferation of counseling professions that were licensed by state boards and were reimbursable by insurance carriers. Prior to the 1960s most insurance carriers reimbursed services provided by the nation's relatively small supply of psychiatrists. But during the twenty years between 1960 and 1980, society's attitude toward therapy for emotional and substance abuse problems changed. The number of counseling professions and professionals expanded. Led by the American Psychological Association (APA) and the National Association of Social Workers (NASW), these professions successfully lobbied for legal recognition as providers of treatment services. By 1977 psychology had achieved regulatory status in all fifty states. At this writing, social work is regulated in forty-eight states, while professional counselors have achieved recognition in thirty-three states. Marriage and family therapists and clinical nurse specialists have statutory recognition as mental health providers in fewer numbers of states. Many of these professionals have successfully developed private practices and achieved a broad appeal to consumers. Some promote the "cost-effectiveness" aspect of their respective professions, comparing their charges in a favorable light with those of psychiatrists.

While these professions found popularity among consumers in the 1970s and 1980s, insurance carriers equated the proliferation of providers with increased service utilization and, in turn, increased costs. Insurance carriers passed on these increases, or the risk for them, to the ultimate private purchaser of health care services—employers.

RISK: THE DYNAMIC THAT DRIVES MANAGED CARE

Risk, when used in its simplest connotation, refers to responsibility or liability for payment for services. Before the advent of health care insurance, an individual was fully at risk for payment for his or her own health care needs. If the individual had an illness or accident, he or she paid a provider (usually a physician) for the unit or units of treatment received. (See Figure 1-3.)

FIGURE 1-3. The Patient at Risk for Health Care Costs



With the development of indemnity health insurance and its proliferation during the 1940s and 1950s as an accepted "benefit" of a job, employers took on a large portion of this risk for payment. The employer paid a premium to a health insurance company who then reimbursed a provider (usually a physician or hospital) for care provided to a patient (the employee or family members). This traditional indemnity insurance system maximized consumers' ability to choose the provider or facility from whom they would receive services. It also tended to motivate providers to focus on customer satisfaction while conducting more services, since reimbursement was based on number of services performed. As utilization (number of services performed) grew, insurance companies would periodically reevaluate their costs and charge higher premiums to the employer. As employers purchased policies from insurance companies that included coverage for mental health and substance abuse treatment they took on greater risk for the cost of services delivered by the various counseling professionals and inpatient treatment facilities. In this system, insurance carriers functioned as passive claims payors. Consumers selected the provider while the providers selected and delivered treatment services, which were ultimately funded by the employer through premiums paid to the carrier. Consumers contributed through their payroll deductions and "deduct-

ible charges” but employers contributed the majority of the total insurance costs. (See Figure 1-4.)

As health care costs rose in the 1980s, employers increasingly felt themselves in an uncomfortable bind. Faced with a more competitive environment, they struggled for means to contain the escalating impact of health care on their profits, while searching for ways to provide adequate care for their employees’ mental health and substance abuse treatment needs. Led by IBM in the early 1980s, most of the nation’s large employers developed or expanded their Employee Assistance Programs (EAPs). Many, already utilizing managed care in the forms of HMOs and PPOs, turned to these organizations as models to address the quandary of how to provide adequate care while containing the escalating mental health and substance abuse care costs. The MBC specialty firm came into existence to meet this market’s needs. (See Figure 1-5.)

FIGURE 1-4. Indemnity Insurance: Employer and Carrier Share Risk

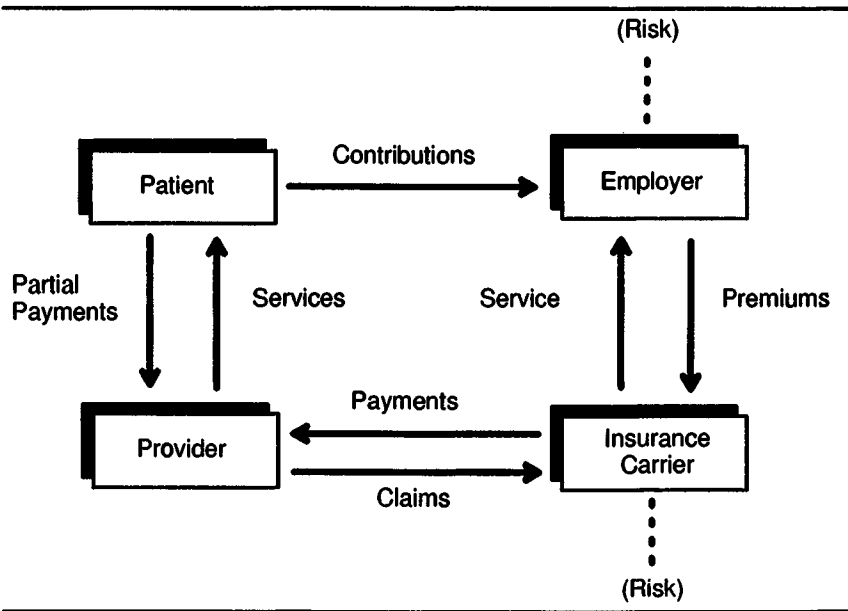
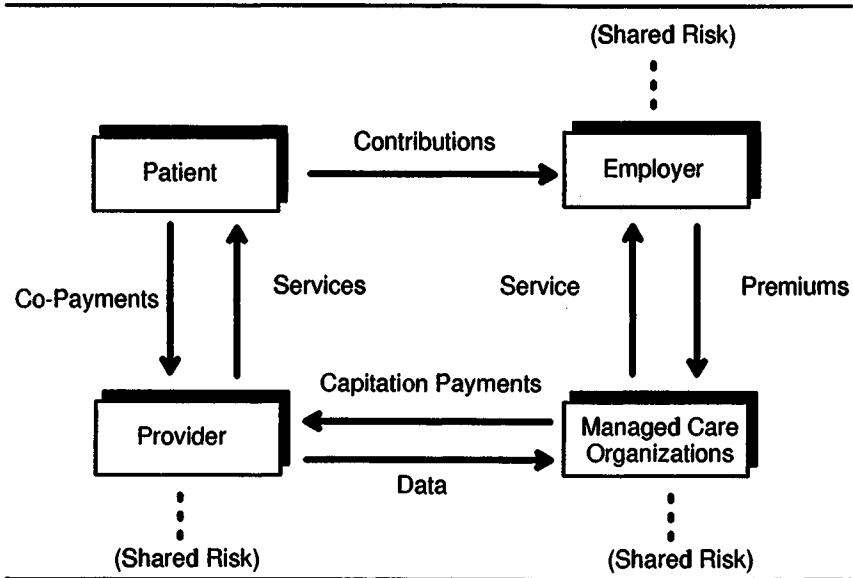


FIGURE 1-5. Sharing Risk Through Managed Care



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Chapter 2

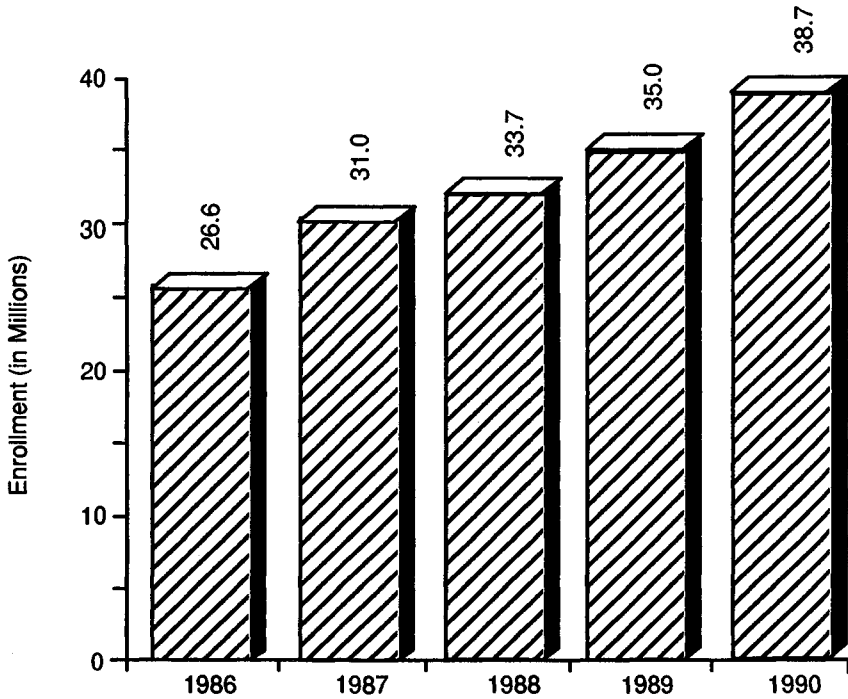
Managed Care Basics: Health Maintenance Organizations

Managed Behavioral Care systems have been largely derivations of and outgrowths from Health Maintenance Organizations and Preferred Provider Organizations, and MBC entities utilize many of the technologies, values, and structures inherent in these organizations. Moreover, HMOs represent a major market for MBC firms, which manage the HMO customer's mental health and substance abuse services. A familiarity with the fundamental operations of HMOs and PPOs provides the background necessary for understanding the developments in Managed Behavioral care.

Health Maintenance Organizations (HMOs) number over six hundred in this country today, and provide health care to thirty-five million Americans. HMOs are large, complex, highly regulated businesses that can operate as for-profit or nonprofit entities. Unlike traditional health insurance carriers, which function largely as claims payors, HMOs both deliver and finance health care. They also differ from traditional carriers in that they provide preventative services and have as part of their focus the "maintenance" of health, not just the treatment of illness. HMO membership grew 10.5 percent in 1990, a major increase after two years of sluggish growth. Analysts predict HMOs will continue to grow in the 1990s as new products are made available. (See Figure 2-1 and Table 2-1.)

The trade association for the HMO industry is the Group Health Association of America (GHAA). It publishes a periodical about the industry called *HMO Magazine*. GHAA's address is listed in the Resource Directory section of this book. GHAA can provide a

FIGURE 2-1. HMO Enrollment, 1986-1990



Source: *Marion Merrell Dow Managed Care Digest/HMO Edition*, 1991, p. 7.

range of information about its member HMOs and the industry in general.

The leading managed health care research and policy analysis institution is the nonprofit InterStudy Center for Managed Care Research (see the Resource Directory for InterStudy's address). InterStudy provides business managers, policy makers, analysts, and clinicians with current data about HMO trends and developments. It publishes *InterStudy Edge*, a widely read quarterly publication.

HMOs provide services (medical, dental, pharmaceutical) to their subscribers, called "members," on a prepaid, fixed fee basis;