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Declining psychiatrist participation in health insurance networks: Where do we go from here?

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More than one-half of individuals with a mental illness do not receive any mental health services.[1] Among those who perceive an unmet need for mental health services, financial concerns represent important barriers to care.[1] The implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Affordable Care Act (ACA) of 2010 will potentially reduce cost-related barriers to mental health treatment by improving the level of coverage for mental health services among those with health insurance, and by expanding insurance coverage to previously uninsured populations.

In the February 2014 issue of JAMA Psychiatry, Bishop et al report results from the National Ambulatory Care Survey showing low acceptance rates for noncapitated insurance by psychiatrists.[2] Bishop et al, found that in 2009/2010 a lower percentage of office-based psychiatrists accepted health insurance (55.3%) compared to other office-based specialist physicians (88.7%). Moreover, the rate of participation in health insurance networks has declined faster among psychiatrists in recent years than among other specialists.

The relatively small number of psychiatrists accepting insurance may undermine the ability of the MHPAEA and the ACA to reduce financial barriers and expand access to care for those in need of psychiatric treatment. A shortage of psychiatrists participating in insurance networks can result in long wait times for an intake appointment or an inability to find an in-network psychiatrist that accepts new patients. Clients that rely on out-of-network psychiatrists for treatment incur higher out-of-pocket costs. While approximately four-fifths of commercially-insured employees are enrolled in a type of plan (e.g., preferred provider organization) that typically offers some coverage for out-of-network providers, these benefits are associated with higher out-of-pocket costs due to higher deductibles, copayments, coinsurance, and/or “balance billing” charges (i.e., the difference between what the provider charges and the maximum amount that the insurer is willing to pay for a service).[3]

The low rate of psychiatrist participation in health insurance networks is especially acute in the Medicaid program, which is the largest payer of mental health services in the United States and disproportionately serves those with the most severe and disabling mental health

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disorders such as schizophrenia.[1] Bishop et al found that just over 4 out of 10 psychiatrists (43.1%) accepted Medicaid in 2009/2010; only dermatologists had a lower rate of Medicaid acceptance.[2] States that opt into the ACA's Medicaid expansion will experience a substantial increase in the percentage of residents with mental health disorders covered by Medicaid, and an increase in the number of users of mental health services.[4] These changes are likely to stress the already overburdened system of Medicaid mental health providers.

Several factors likely contribute to psychiatrists' low participation in Medicaid and other health insurance networks. One possibility involves the relative reimbursement rates for the types of procedures for which psychiatrists are commonly reimbursed -- psychotherapy and medication management. Because psychotherapy can also be provided by other professionals such as Master's level therapists, reimbursement rates for psychotherapy visits are lower relative to medication management visits. The relative difference between these reimbursement rates incentivizes psychiatrists who accept health insurance to focus on medication management visits.[5] For many psychiatrists, however, a practice consisting only of time-limited medication management visits may be personally unfulfilling and at odds with their values about how to practice good psychiatry. The coordination of care with other providers and social services sectors (e.g., schools) and the delivery of culturally competent, patient-centered care may require more time than the 10 to 15 minutes typically allotted for medication management visits by insurance plans.

The small size of psychiatry practices may also contribute to psychiatrists' low participation in health insurance networks. More than half of office-based psychiatrists have solo practices,[2] which has substantial consequences for administrative costs among those that accept health insurance. The time required to negotiate contracts with health insurance companies, file prior authorization forms, file claims, and recover payments for services requires additional staff and a concomitant increase in office space. The revenue associated with participating in insurance networks may not be sufficient to offset these additional overhead expenses for many psychiatrists in solo practices.

The overall shortage of psychiatrists is a third factor potentially contributing to low participation in insurance networks. Because more than three-quarters of U.S. counties have a severe shortage of psychiatrists,[6] the absence of competition can give psychiatrists the flexibility to choose how they want to practice, and can facilitate the development of practices comprised exclusively of clients that can pay out-of-pocket. Supply-side trends also suggest that the shortage of psychiatrists may worsen in coming years. The number of graduates from psychiatry residency programs declined 14% between academic years 2000-2001 and 2007-2008,[7] the current psychiatry workforce is aging (46% are age 65 and older), and the number of psychiatrists has not kept pace with population growth.[8]

Given the declining participation rate of psychiatrists in insurance plans, how can health care delivery systems be modified to ensure that health insurance expansions result in improved access to mental health care? One strategy is to incentivize greater participation among the existing workforce in insurance plans by increasing reimbursement rates for psychiatric services. However, in many markets, it would be very costly for health plans to

raise reimbursement rates to high enough levels that could compete with what psychiatrists can charge patients who pay out-of-pocket.

Another approach is to increase the size of the psychiatry workforce. However, this would take many years to implement because of the time involved in training specialist physicians. One caveat is that a larger workforce may not increase the number of psychiatrists who locate their practices in areas with a shortage of psychiatrists, or who accept health insurance.

A third, and potentially the most promising solution, is to further develop collaborative chronic care models (CCMs), which implement team-based approaches to provide stepped care for those with mental illnesses and other chronic conditions.[9] These models rely on primary care providers to provide treatment for mild to moderate mental health disorders with support from case managers and consultation from mental health specialists. CCMs make efficient use of psychiatrists' time by enabling them to provide decision support for primary care teams and direct treatment for the most complex psychiatric patients. There are, however, a number of barriers to wide dissemination of CCMs such as limited flexibility in reimbursement mechanisms to support team-based care, limited resources available to train participating providers, and limited integration of health information technology systems among community-based providers to facilitate sharing of patient medical records. By offering opportunities to develop infrastructures such as accountable care organizations for Medicare enrollees and medical homes for Medicaid enrollees with "serious and persistent mental illness," the ACA might minimize these barriers for target populations and facilitate implementation of team-based stepped care approaches to mental health treatment.

Recent federal laws that expand health insurance coverage for mental health services have the potential to improve access to mental health care by reducing cost-related barriers to treatment. If low rates of psychiatrist participation in insurance networks persist and continue to decline, health care delivery models that make efficient use of psychiatrists' time among those that do participate in health insurance networks will be needed. Further development and dissemination of team-based approaches in which primary care providers and psychiatrists work collaboratively offer one mechanism to meet the needs for mental health treatment in the United States.

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