Mental Health Disparity Version 2.0:

An Open Letter About Financial Discrimination Against Mental Health Services

Ivan J. Miller May 6, 2009

Mental health advocates have won the battle to achieve parity for mental health services paid by health insurance. Almost everywhere laws prohibit the overt financial discrimination against mental health services. With the old forms of disparity outlawed, insurance discrimination against mental health services has reemerged as Mental Health Disparity Version 2.0. The new disparity is more than the obvious invasions of privacy, special authorizations, and extensive paperwork required only for mental health patients. It is also a systematic pattern of low provider reimbursements that impairs access to quality services by forcing psychiatric units to close and by driving quality providers out of the field. As mental health advocates, we need to, and can do, something to stop Disparity 2.0.

The evidence assembled here validates that there are differences in the way insurance companies reimburse mental health care and physical health care, and that the differences cause difficulties accessing quality mental health services. It is not the ordinary marketplace nor is it competition among mental health professionals that has created the funding shortages. The insurance company system for managing mental health care is not just discriminatory, but it consumes a large portion of the funds intended for providing mental health services. Based on this review of the evidence, an action plan is proposed to end the ongoing discrimination of Disparity 2.0.

Historically, when patients pursued mental health care, in comparison to physical health care, insurance imposed significantly higher copayments, much lower annual and lifetime maximums, and larger deductibles. This Version 1.0 funding disparity between physical and mental health was obvious discrimination, and the campaign to end it was called the mental health parity campaign. After victories in most states, the last major battle was won on October 3, 2008 with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Now, with Disparity 2.0, there are substantial funding problems for mental health services. There is clear evidence that the problems with funding and reimbursement are not the natural result of market forces, but that they are the result of a pattern of discrimination against mental health services. As with traditional disparity, the discrimination is primarily a result of the practices of the health care insurance industry, not the actions of government or society in general.

The closure of psychiatric units across the country is the clearest evidence of the managed mental health care discrimination against mental health services. There is a well-documented shortage of psychiatric hospital beds. The Denver Post (K. Aug_, Psyc. Units Shutting Doors, 1/25/09) reports that the U.S. has an average of 30 psychiatric beds/100,000 population. In contrast, Canada has 190 psychiatric hospital beds/100,000 (M. Lang, Calgary Herald, Mental Health Bed Shortage, 4/21/09). The American College of Emergency Physicians has extensively documented that the psychiatric hospital shortage is a serious nationwide problem. When psychiatric beds are unavailable, ERs are backed due to holding and boarding psychiatric patients (ACEP Psychiatric and Substance Abuse Survey 2008). This not only is inappropriate treatment for mental health patients, it also interferes with service to other ER patients.

How is Disparity 2.0 responsible for the dramatic shortage of psychiatric hospital beds? The answer is found in understanding reimbursements. The Denver Post (K. Aug_, Psyc. Units Shutting Doors, 1/25/09) reports that hospital directors say that the psychiatric units are closing because, even when patients have insurance, the insurance doesn't cover 100% of the cost of care on these units. As with most hospital units, public payer patients and the uninsured also pay less than the cost of care. The disparity is that in physical health care, insurance typically pays 131% of the cost of services (Lewin Group, final report to the Colorado Blue Ribbon Commission on Health Care Reform, 2007). This pattern of under-payment by public payers and the uninsured, and over-payment by

insurance is called cost shifting. Cost shifting, or the insurance over-payment is what keeps our physical health care hospital units open. The insurance system underpays psychiatric hospital units contributing to the underfunding, but it accepts the cost-shifting burden and overpays for medical inpatient costs, which allows physical health care units to remain open.

The result of the inpatient reimbursement disparity is the closure of psychiatric hospital units. With the units closed, patients who do not have an inpatient option may be boarded in emergency rooms or jails; are discouraged from trying to obtain services; and are discharged prematurely to allow for the triage workers to admit other patients to the hospital beds.

Disparity 2.0 has a more insidious, but still deleterious, impact on outpatient services. From a patient's point of view, some features of the special mental health management are obvious. Patients are screened by a special mental health referral system, treatment is under constant vigilance of the managed mental health care entity, there is often difficulty finding an appropriate therapist within a panel, and frequently, recommended therapists are not available on the treatment panels.

Not obvious to patients, there is a pattern of declining reimbursement rates for mental health providers over the past 20 years. Most managed mental health care entities have not raised mental health reimbursements for 20 years, and in many cases, they have lowered reimbursements. Consequently, mental health professionals have arguably the worst reimbursements in health care, and many are leaving the field or working outside of the health care insurance system.

I recently became acutely aware of how poorly informed the public is about the reimbursement crisis in mental health. I am actively involved in health care reform advocacy, policy development, and writing policy for grassroots health care reform. In discussions with reform advocates and legislators there are few issues that everyone is aware of and in agreement. But two issues have almost universal acceptance,

- Every group I meet with is clear that mental health must be included in health care reform and that there must be parity. This opinion is expressed by everyone, not just representatives of mental health. Advocates have effectively convinced the public that mental health services are important and that parity is important.
- The second universal concern is that primary care physicians and nurses are underpaid, and health care reform must address reimbursements for primary care. Sometimes, other professions such as physical therapists are included in the underpaid group, but mental health professionals have never been included. In spite of the far more severe reimbursement problem, the mental health professions have allowed our reimbursement problems to occur in virtual secrecy.

Within psychology group discussions, there are two myths that keep us from effectively addressing the reimbursement problem. First, there is the myth that mental health professionals have not had an increase in reimbursement for twenty years because of some natural market force. Second, doctoral level psychologists have assumed that reimbursements have fallen because they are paid the same as master's level practitioners.

Recently, as part of my health care system research, I was placing my family medical bills, reimbursements, adjustments, and out-of-pocket expenses on an Excel worksheet as an example of a consumer with high medical expenses. In the process, I became aware that the insurance market forces operated differently for physical health care than for mental health care. I realized that my physical therapist had a 3.7% increase in reimbursement from Anthem Blue Cross in the middle of the year. She has a master's degree and an office set up that is no more expensive than a psychologist's office. She is reimbursed at $72 for a 25-minute session, and Anthem pays a psychologist $72 for a 50-minute session. She receives twice the psychologist pay. She is on the medical track where market forces determine her reimbursement with regular increases. In mental health there are no annual adjustments, and occasionally even periodic reductions. Physical health care uses a different system for determining reimbursement than mental health care.

Other facts indicate that the managed mental health care is a special market manipulation that artificially lowers reimbursement. Medicare rates are determined by a formula that considers the difficulty of a task, the costs, and the education and skills necessary to perform the service. The reimbursement that results from this formula is considered to be around 80% the actual cost of doing business, and providers are expected to obtain higher reimbursements from commercial insurance so that the cost shifting can subsidize the below cost reimbursement from Medicare. As described in the Colorado Lewin analysis, insurance companies paid 131% of the cost of providing services. This difference occurs because the pattern in physical health care is that market forces result in private and commercial insurance paying much more than Medicare. Even the most publicized area of under-reimbursement in physical health care, primary care, is not the result of market forces. Commercial insurance reimburses primary care adequately, and the problem is that the bureaucratically determined rates from Medicare under-reimburse so severely that even with cost shifting, primary care practitioners sometimes cannot stay in business.

In the managed care manipulation of mental health the opposite is the case. I conducted a survey of the 14 most common insurance plans in Boulder, Colorado and found that insurance pays around 80% of Medicare rates. As it turns out, Medicare, whose formula is intended to reimburse at below the cost of providing services, has one of the highest reimbursement rates. Something different is going on with mental health services than with physical health care, and it is not just market forces. Whereas market forces allow physical health care providers to satisfactorily earn a living, the special market manipulation reserved for mental health is forcing many of the most qualified providers to leave the field higher income.

Part of the answer to understanding Disparity Version 2.0 is in the structure of providing mental health services through special managed mental health care entities, often called carve-outs. Between 25% and 30% of health care funds are spent on administration and profit. However, in mental health a much higher proportion is devoted to administration and profit, keeping health care funds away from patients and providers. Creative accounting methodology considers all of the funds assigned to a managed behavioral health care carve to be funds spent on mental health services. Therefore, in physical health care, after skimming the 25–30% for administration and profit, the remainder of funds is assigned to providers. Not so in mental health. After the 25–30% is skimmed from the premiums, the mental health portion is assigned to a mental health carve out, which actually takes another huge portion of the funds for administration and profit. Determining the amount that behavioral health care takes for administration and profit is difficult because operation of these entities is a proprietary secret. The last insider estimates that I was able to obtain for this administration and profit expense came in the late 1990s from James Wrich, a managed behavioral health care company auditor. He reluctantly reported that, because it sounded so unbelievable, that he had never audited a managed behavioral health care company that took less than 50% for administration and profit if it was at risk for the cost of services. Personally, I have had a couple of executives in managed behavioral health care organizations admit that it is well known that managed behavioral health care is significantly more expensive than managed physical health care.

So part of the answer to what happens to mental health services and reimbursements is that a significantly larger portion of the mental health care dollar is diverted to pay for the administration and profit of managed behavioral health care companies. The purpose of the managed mental health carve out companies is to limit services and funds spent on patients. With the overall administration and profit expenditures of insurance between 25–30%, and a conservative estimate of the behavioral health care administration and profit costs being at 30–35%, only 52.5% to 45.5% of the health care funds remain for the delivery of services to patients. *Around half of mental health's share of insurance money is spent on administrative and profit, and the extra administration is intended to reduce the payment of services*. Is this necessary or is it discrimination? Does this sound like a normal market, with over half of the money going to administration and profit? Does this seem more like a financial scheme to divert funds intended for the treatment of mental illness?

The second myth is one that is often discussed by my professional group, doctoral degree psychologists. Many doctoral level providers believe that their reimbursements are low due to a mistaken belief that they are paid the same as master's level professionals.

Throughout the system, psychologists are consistently paid more than master's degree professionals. It is well established that professionals with markedly different levels of education and expertise are compensated at a higher level. In my own survey of 14 insurance companies, there was only one managed care company that did not pay more to psychologists than master's level therapists. The pay to psychologists was poor, but the pay to master's level therapists was even worse. The only portion of mental health that is commensurate with physical health care is psychiatry. I think this is because there is a psychiatrist shortage, and as MDs they are considered part of the medical rather than the mental health profession.

The result of the low reimbursement is demonstrated below in some statistics from the *U.S. Bureau of Labor Statistics, 2006* website.

- A median annual earnings of mental health and substance abuse social workers was $35,410. http://www.bls.gov/oco/ocos060.htm
- Marriage and family therapists median was $34,660 http://www.bls.gov/oes/2000/oes211013.htm
- Psychologists median $59,440, and for the category of psychologists in offices as mental health practitioners, the median is $69,510, http://www.bls.gov/oco/ocos056.htm
- Median hourly wage for carpenters is $17.39, and if this is converted to annual salary it is $36,171 http://www.bls.gov/oco/ocos202.htm
- Auto mechanics at car dealers, median is $18.85/hr., converted to an annual salary is $39,208, http://www.bls.gov/oco/ocos181.htm
- Physical therapists (the majority in this group are employed by a group or hospital and not in private practice), median, $66,200, http://www.bls.gov/oco/ocos080.htm
- Nurses, median $57,280, http://www.bls.gov/oco/ocos083.htm
- Family Practice physicians with over one year in practice, median $156, 010, http://www.bls.gov/oco/ocos074.htm
- Psychiatrists with over one year's experience, median $180,000, http://www.bls.gov/oco/ocos074.htm

The reimbursement problem can also be demonstrated by comparing the annual income of a psychologist and a licensed master's level therapist when reimbursed by Medicare, with the annual income when reimbursed by a typical managed behavioral health care company. The comparison is based on the reimbursement rates in my Colorado survey. Assuming that a psychotherapist would have 30 billable hours a week of patients; work a 48 week year (no pay for sick days, family emergencies, holidays, overtime, or professional training); have no loss due to uncollected fees; and have $42,000 of office expenses as I do, in Colorado. It should be noted that the resulting salaries below do not include employer paid health insurance benefits.

1. A psychologist would have an annual income of $89,357 if all of the patients were Medicare.
2. A psychologist would have an annual income of $61,680 if all of the patients were typical in-network insurance patients.
3. A licensed master's level therapist would have an annual income of $61,680 if all of the patients were Medicare.
4. A master's level therapist would have an annual income of $47,280 if all of the patients were typical in-network insurance patients.

Although the above compares psychologists with master's level therapists, all non-MDs are in the same boat when it comes to discriminatory reimbursement levels. A rising tide lifts all boats. However, when the tide or water level goes down, blaming the captains of other boats does nothing to lift one's own boat. Mental health practitioners include doctoral level psychologists as well as social workers, family therapists, and counselors. They are all necessary as treatment providers, and they are all the victims of the managed mental health market manipulation. If the professions blame each other, we will all sink, and while sinking we will maintain a level of discord and conflict that is

a blemish on our professions. ***We need to make an alliance with all professional groups, and with consumer groups, to fight the real problem***—those managed care entities, health care economists, and insurance companies which use mental health funds for their own profit, not for the welfare of mental health patients.

Adequate mental health services occur when patients can find a therapist able to deal expertly with their needs, and when conditions allow the treatment to continue as long as necessary. Therapists have varying specialties, and for therapy to be optimally successful, it is important to find a therapist that meets a patient's interpersonal and treatment needs. Traditionally, referral networks help patients locate the right therapist. When reimbursement rates are low, provider panels are limited. Traditional referral networks are disrupted by these limited panels. Some patients simply are unable to find appropriate therapists.

The American Psychological Association Interdivisional (39/42) Task Force on Managed Care and Health Care Policy (for which I serve as co-Chair) has obtained several surveys showing that insurance provider panels often contain names of unavailable providers (phantoms). These "Phantom Panels" give the illusion of access to mental health care. These studies show patterns of provider shortages—usually there are very few, if any, providers who are available and able to deal with specialized areas of treatment such as child therapy, treatment of teens, dual diagnosis, etc.

It is not desirable, from a patient's point of view or society's point of view, to have a mental health system in which master's level therapists earn little more than skilled laborers like carpenters and doctoral level psychologists working for the typical managed care entity earn at the pinnacle of their career only slightly more than occupations that do not require a bachelor's degree. The low reimbursements cause a brain drain, with obvious deleterious effects on mental health services.

In discussion of Disparity 2.0 with colleagues we have developed ideas about a strategy for addressing low reimbursements and the resulting effects on access to quality mental health services. I believe that if an alliance of mental health care professionals could win the Mental Health Parity battle, we can also win the Disparity 2.0 battle. In the Parity battle, we learned that the public does not support the insurance driven discrimination against mental health care, and when informed, they will be on our side. The public wants their health care premiums to be spent providing health care, not creating large, profitable managed mental health care carve-outs.

The alliance of mental health advocates who won the Mental Health Parity battle can implement the following course of action.

1. Advocacy groups should maintain a strong and primary focus on adequate reimbursement and adequate patient access to traditional treatment services including inpatient services; individual, family, and group psychotherapy; and psychological testing. Professional organizations have too often avoided the reimbursement crisis by encouraging their members to find other sources of income.
    (a) Many professional organizations are addressing the reimbursement crisis by suggesting that their members pursue other services such as coaching, psychologist prescription privileges, and new niches. These new services are valuable, but are not a reason to divert attention from offering traditional mental health services.
    (b) Some professional groups are advocating for including mental health in all aspects of health care reform. These groups advocate for integrating delivery of mental health services with primary care. Increasing availability of mental health services through primary care is valuable but irrelevant to promoting the most important issues—adequate reimbursement and adequate level of services. In the 1990s, health care economists promoted integrated delivery, group practices, one-stop shopping, and services combined with primary care providers. Some of these are relevant to future mental health services. However, these developing services were not as important as their proponents claimed in the 1990s, and now, they still do not address the problem with reimbursement and adequate level of services. As my Texan colleague says, "How is it better to eat a bowl of tasteless non-nourishing

gruel in a primary physician's office, either as an employee or private practitioner, than it is to swallow the same managed care gruel in your own office? The problem is the stuff we need to swallow, not the location where we are forced to eat it."

2. Mental health advocates need to make a commitment to an overall strategy and campaign that results in health care reform advocates across the country insisting that health care reform include four elements:
   (a) Inclusion of the full range of mental health services.
   (b) Traditional mental health parity for deductibles, copayments, and benefit limits.
   (c) Adequate reimbursement for mental health services.
   (d) Access to adequate services for mental health patients.

   This campaign should result in the level of reimbursements and services being addressed as often as the inadequate reimbursements for primary care providers and nurses are mentioned. Judging by the success of the mental health parity campaign, the pro-mental health campaign, and the primary care practitioner's campaign, it is reasonable to expect that an adequate reimbursement and adequate level of services campaign can receive widespread public support and eventual success in health care reform. This strategy should include

   a. *Building alliances* among all mental health professionals and consumer groups, just as the successful parity campaign was based on these alliances
   b. A comprehensive effort by the professional groups to *document* the number of professionals who are leaving clinical work due to the poor reimbursements and the financial difficulty that mental health professionals encounter in the current health care reimbursement system
   c. *Comprehensive study* of why and how the health care system is unfairly targeting mental health services These studies would include survey research of reimbursement practices and phantom networks in mental health and a comparison of these practices to practices in physical health care, and they would connect the dots between poor reimbursement and limitations in access to mental health services. This research is necessary to describe Disparity 2.0. This research should cost no more than several hundred thousand dollars, not too much to protect the financial survival of the mental health professions.
   d. A comprehensive effort to *end the practice of diverting a larger portion of mental health funds to administration and profit than is diverted in physical health care*.
   e. While this article focuses on the role the private insurance industry plays in Disparity, 2.0, the campaign for True Parity needs to *include the public payers that fund services for the severely and chronically mentally ill*.
   f. A *public education component* that includes press releases, publications, and communication with the media. The public education would emphasize the relationship between discriminatory reductions in reimbursement for mental health services and a discriminatory reduction in access by the public to quality mental health services.
   g. A *lobbying component* that calls for addressing the problem of inadequate reimbursement in all health care reform legislation

3. Mental health advocates need to make a commitment to use the expert services of attorneys and health care economists to promote mental health services, not to confine or hide the problems involved in delivering mental health services. Too often the mental health professional organization attorneys have focused narrowly on preventing the slightest risk of anti-trust violations. They have encouraged mental health professionals to be silent about reimbursement problems even as our professions are being suffocated. The tax attorneys have focused narrowly on preserving nonprofit tax advantages of mental health professional organizations, and urged mental health professionals to be silent about their needs for financial survival, all the while, missing the bigger picture that patients cannot access health care services without a professional workforce. These organizations have employed health care economists, well paid to predict success or disaster and influenced primarily by the biggest players, insurance companies, to direct mental health professionals to be compliant with the managed behavior health care entities. The mental health professional organizations

have not adequately employed expert advice to address the kind of discrimination that is emerging in Disparity 2.0.

Primary care and nursing professionals have successfully conducted campaigns that address inadequate reimbursement, and they do not appear to be violating anti-trust laws nor do they appear to be doing anything that would violate nonprofit status. Mental health has successfully campaigned for improved reimbursements in parity legislation, and this advocacy did not violate anti-trust or nonprofit laws. Moreover, addressing access to mental health services does not violate anti-trust or nonprofit laws, and reimbursements are the core of the access problems in mental health. Advocacy is possible and necessary.

1. Mental health professional organizations need to tell the anti-trust attorneys to find a way within the anti-trust laws to fashion a *successful* campaign to address the reimbursement and adequate services problems that are the core of Disparity 2.0.
2. Mental health professional organizations need to tell the 501(c)(3) attorneys to find a way within the nonprofit laws to fashion a successful educational campaign to address the reimbursement and adequate services problems that are the core of Disparity 2.0.
3. Mental health professional organizations need to employ health care economists to help analyze Disparity 2.0 and help mental health professionals design a strategy to address and correct Disparity 2.0.

The final question that remains is, “Why has mental health been singled out for such disproportionate discrimination by insurance companies?” I do not believe that the insurance companies or managed mental health care entities hate mental health patients. I do believe that these entities are inclined to take money where it is easy to take. I have a managed-care-free practice and make a living as a psychologist treating patients who will self-pay or go out-of-network to obtain my services. In other words, I treat patients who are so dissatisfied with managed mental health care services that they would rather pay the full cost of treatment out-of-pocket than see a managed care provider. Over the past 23 years, I have only had two patients who made small protests to insurance or to their employer about inadequate in-network mental health services. Because of the stigma and emotional drain of mental health problems, my patients would rather just pay me than complain or attract attention to their problems. On the other hand, when there is a problem with physical health care or access to a physical health care provider, many of my patients have been willing to battle with their insurance company. I think that the stigma and drain of mental illness is the only explanation needed to explain why mental health is vulnerable, and when a financially vulnerable population exists, it is the responsibility of the professionals to do the educating and the advocacy.

Managed behavioral health care companies have only one customer, the insurance company. How they operate their businesses is a proprietary secret. They are a special entity within the insurance industry, and exist for the purpose of limiting the funds spent on mental health care. As the overt forms of disparity have been outlawed by parity legislation, it is not surprising that these poorly regulated entities are continuing the tradition of discrimination.

So what is different about how health care insurance handles mental health services compared to physical health services? The goal of insurance companies is not to foster societal goals such as insuring everyone. The goal of insurance companies is to sell insurance policies that produce a profit, even if one out of seven people in the U.S. are uninsured. Likewise, insurance is not concerned with maintaining the workforce required for access to quality inpatient and outpatient mental health services. In physical health care, apparently, the insurance industry believes that in order to sell profitable insurance policies, it must adequately reimburse physical health care. Therefore, it cares about accessibility to quality physical health care services. On the other hand, although the law requires that most health insurance include mental health services, apparently, insurance does not see a need to adequately reimburse these services. The reasons may be that mental health is a minor part of health care, the beneficiaries of these services are unlikely to complain, and there is a history of years of insurance-driven financial discrimination. *The bottom line is that the health care insurance system does not care about access to quality mental health services, and the reality is that it prefers to reduce funding in spite of harming access to quality*

health care services. Cutting funding for mental health services probably increases health care insurance profitability, and therefore, the insurance industry has developed financing systems that end up contributing to the historical discrimination against mental health services.

Conclusion

This open letter calls for a new, organized direction and effort by all mental health advocates to address the problems in Disparity 2.0. Achieving the social goals of access to quality mental health care will not come spontaneously from insurance companies, but will only come from public and governmental pressure. If we keep our alliance, and keep our focus, we can create adequate reimbursements for inpatient treatment until we have restored an adequate number of psychiatric beds. We can reverse a 20 year pattern of reducing provider reimbursements. We can reestablish mental health professions as middle-income professions. And we can assure patients of an adequate selection of providers who can treat their individual and special needs. Victory in the battle over Disparity 2.0, the same as the victory in the Mental Health Parity battle, will avoid the tendency to dwell on our conflicts, and require that we maintain our alliance in order to lift all boats.

Addendum regarding health care reform

The colleagues who have helped with this paper and I have developed a hybrid health care financing proposal, Balanced Choice, that combines the benefits of a public system with market forces, and bypasses the need for insurance companies. It would eliminate the insurance-driven discrimination against mental health services and prevent the administrative waste and abuses of insurance-driven healthcare. This hybrid has the administrative efficiency of a single payer system without the rigid reimbursement rules that other single payer systems employ. As a hybrid, it has the ability to attract advocates of both market driven systems and single payer systems. Information about Balanced Choice is available at www.BalancedChoiceHealthCare.org.

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