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Rates of Psychiatrists' Participation in Health Insurance Networks

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Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care

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IMPORTANCE There have been recent calls for increased access to mental health services, but access may be limited owing to psychiatrist refusal to accept insurance.

OBJECTIVE To describe recent trends in acceptance of insurance by psychiatrists compared with physicians in other specialties.

DESIGN, SETTING, AND PARTICIPANTS We used data from a national survey of office-based physicians in the United States to calculate rates of acceptance of private noncapitated insurance, Medicare, and Medicaid by psychiatrists vs physicians in other specialties and to compare characteristics of psychiatrists who accepted insurance and those who did not.

MAIN OUTCOMES AND MEASURES Our main outcome variables were physician acceptance of new patients with private noncapitated insurance, Medicare, or Medicaid. Our main independent variables were physician specialty and year groupings (2005-2006, 2007-2008, and 2009-2010).

RESULTS The percentage of psychiatrists who accepted private noncapitated insurance in 2009-2010 was significantly lower than the percentage of physicians in other specialties (55.3% [95% CI, 46.7%-63.8%] vs 88.7% [86.4%-90.7%]; *P* < .001) and had declined by 17.0% since 2005-2006. Similarly, the percentage of psychiatrists who accepted Medicare in 2009-2010 was significantly lower than that for other physicians (54.8% [95% CI, 46.6%-62.7%] vs 86.1% [84.4%-87.7%]; *P* < .001) and had declined by 19.5% since 2005-2006. Psychiatrists' Medicaid acceptance rates in 2009-2010 were also lower than those for other physicians (43.1% [95% CI, 34.9%-51.7%] vs 73.0% [70.3%-75.5%]; *P* < .001) but had not declined significantly from 2005-2006. Psychiatrists in the Midwest were more likely to accept private noncapitated insurance (85.1%) than those in the Northeast (48.5%), South (43.0%), or West (57.8%) (*P* = .02).

CONCLUSIONS AND RELEVANCE Acceptance rates for all types of insurance were significantly lower for psychiatrists than for physicians in other specialties. These low rates of acceptance may pose a barrier to access to mental health services.

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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) and the Affordable Care Act (ACA) 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 *JAMA Psychiatry*, Bishop et al[2] report results from the National Ambulatory Medical Care Survey showing low acceptance rates for noncapitated insurance by psychiatrists. Bishop et al found that in 2009-2010, a lower percentage of office-based psychiatrists accepted private health insurance (55.3%) compared with 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. Patients who rely on out-of-network psychiatrists for treatment incur higher out-of-pocket costs due to higher deductibles, copayments, coinsurance, and balance billing charges.[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 disabling mental health disorders, such as schizophrenia.[1] Bishop et al[2] found that slightly more than 4 of 10 psychiatrists (43.1%) accepted Medicaid in 2009-2010; only dermatologists had a lower rate of Medicaid acceptance. States that opt into the ACA's Medicaid expansion will experience an increase in the percentage of residents with mental health disorders covered by Medicaid and in the number of users of mental health services.[4] These changes are likely to stress the already overburdened system of Medicaid mental health practitioners.

Several factors likely contribute to psychiatrists' low participation in Medicaid and other health insurance networks. One possi-

bility 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 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 clinicians 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 who accept health insurance. The time required to negotiate contracts with 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 participation in insurance networks may not be sufficient to offset these additional overhead expenses for 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 US 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 comprising exclusively clients who can pay out-of-pocket. Supply-side trends also suggest that the shortage may worsen in coming years. The number of graduates from psychiatry residency programs declined 14% between academic years 2000-2001 and 2007-2008,[7] 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. Moreover, a larger workforce may not increase the number of psychiatrists who locate their practices in underserved areas or who accept health insurance.

A third approach, and potentially the most promising, 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 clinicians to provide treatment for mild to moderate mental health disorders with support from case managers and consultation from mental health specialists. Chronic care models make efficient use of psychiatrists' time by enabling them to provide decision support for primary care teams and direct treatment for patients with the most complex psychiatric needs. However, there are 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 physicians, and limited integration of health information technology systems among community-based clinicians 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 reduce 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 treatment. If low rates of psychiatrist participation in insurance networks persist, health care delivery models that make efficient use of psychiatrists' time among those who do participate will be needed. Further development and dissemination of collaborative team-based approaches offer one mechanism to meet the needs for mental health treatment in the United States.

ARTICLE INFORMATION

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