Reimbursement For Psychologists' Services:

Trends, Impact on Access to Psychologists, and Solutions

Gordon I. Herz, PhD[1]

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Abstract

Efforts to fully integrate psychological services into the broader health care system will fail unless the problem of fair compensation for such services is solved. Reimbursement for psychologists' services under managed care has been declining in real dollars for at least the past 20 years. The financial viability of the independent practice of psychology has been devastated by this trend. Consumer access to psychologists in managed reimbursement environments continues to worsen, with declining numbers of contracted psychologists, and false claims by managed care about the numbers who remain. A for-profit, managed reimbursement financing system is fundamentally incompatible with the independent practice of psychology and unfettered access by the public to doctoral level psychological services. Organized psychology must acknowledge the damage caused to the provision of psychological health services by for-profit reimbursement schemes, utterly reject such an approach in any reformed system, and develop and implement a comprehensive set of actions to usher in a new health care delivery, financing and reimbursement system. Reimbursement trends and resulting limitations in the public's access to psychologists are documented, and recommendations for roles, strategies and actions for our professional organizations are provided.

How we got into the current mess

Conditions are rigged against practicing psychologists. The Sherman Antitrust Act (1890) was passed to (1) prohibit competitors from engaging in acts that result in the unreasonable restraint of trade, and (2) prohibit competitors from exercising monopoly power. Psychologists previously had actually successfully used restraint of trade arguments to broaden practice and public access to psychological services. These days it seems that psychologists operate out of fear – some justified, some irrational – of being accused of anticompetitive activity. The McCarran-Ferguson Act (1945) was passed to specifically exempt insurance companies from federal antitrust scrutiny to the extent that they were regulated by the states. Effectively, this law has given the insurance industry a broad grant of immunity from federal antitrust scrutiny that the learned professions do not enjoy, thus tipping conditions significantly in the industry's favor. Efforts to level the playing field by obtaining its repeal have thus far been unsuccessful. The ruling in Goldfarb v Virginia State Bar, 421 US 773, 95 SCt 2004 (1975) put the final nail in our collective coffin by finding that the learned professions are not exempt from scrutiny under the Sherman Antitrust Act. Thus, in a seemingly inequitable application of the law, healthcare professionals and the entire healthcare industry has been subjected to the threat of vigorous application of the antitrust laws while the insurance industry is largely exempt.

There have been efforts to level the playing field, such as the attempt to enact H.R. 1304, the "Quality Health Care Coalition Act of 1999". This bill would have allowed physicians and other healthcare professionals in independent practice to engage in collective bargaining with health plans and thus be granted antitrust immunity. It was soundly killed by (1) arguments that it would be bad medicine for consumers, (2) testimony by Robert Pitofsky, then Chairman of the FTC, and (3) insurance industry lobbying efforts (your insurance premium dollars at work).

Antitrust Issues

Governmental watchdogs (DOJ and FTC) are charged with interpreting "procompetitive" behaviors as those that insure that prices for goods and services stay as low as possible for consumers. If current compensation levels for a particular trade or profession happen to make if too difficult for their members to stay in business, it may be assumed that the accepted interpretation will be that the unquestioned and unquestionable wisdom of the competitive marketplace has made itself manifest. These agencies have issued related guidance, as follows (Federal Trade Commission, 2008).

"6. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PROVIDER PARTICIPATION IN EXCHANGES OF PRICE AND COST INFORMATION

Participation by competing providers in surveys of prices for health care services, or surveys of salaries, wages or benefits of personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. Providers can use information derived from price and compensation surveys to price their services more competitively and to offer compensation that attracts highly qualified personnel. Purchasers can use price survey information to make more informed decisions when buying health care services. Without appropriate safeguards, however, information exchanges among competing providers may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of health care services. A collusive restriction on the compensation paid to health care employees, for example, could adversely affect the availability of health care personnel.

This statement sets forth an antitrust safety zone that describes exchanges of price and cost information among providers that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. It also briefly describes the Agencies' antitrust analysis of information exchanges that fall outside the antitrust safety zone.

A. Antitrust Safety Zone: Exchanges Of Price And Cost Information Among Providers That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, provider participation in written surveys of (a) prices for health care services,(15) or (b) wages, salaries, or benefits of health care personnel, if the following conditions are satisfied:

> (1) the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);
>
> (2) the information provided by survey participants is based on data more than 3 months old; and (3) there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

The conditions that must be met for an information exchange among providers to fall within the antitrust safety zone are intended to ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs. They represent a careful balancing of a

provider's individual interest in obtaining information useful in adjusting the prices it charges or the wages it pays in response to changing market conditions against the risk that the exchange of such information may permit competing providers to communicate with each other regarding a mutually acceptable level of prices for health care services or compensation for employees.

B. The Agencies' Analysis of Provider Exchanges Of Information That Fall Outside The Antitrust Safety Zone

Exchanges of price and cost information that fall outside the antitrust safety zone generally will be evaluated to determine whether the information exchange may have an anticompetitive effect that outweighs any procompetitive justification for the exchange. Depending on the circumstances, public, non-provider initiated surveys may not raise competitive concerns. Such surveys could allow purchasers to have useful information that they can use for procompetitive purposes.

Exchanges of future prices for provider services or future compensation of employees are very likely to be considered anticompetitive. If an exchange among competing providers of price or cost information results in an agreement among competitors as to the prices for health care services or the wages to be paid to health care employees, that agreement will be considered unlawful per se.

Competing providers that are considering participating in a survey of price or cost information and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of providers who are considering participating in a survey of price or cost information within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted."

Glimpses through the looking glass: Phantom networks and the vanishing mental health dollar trick

The managed care industry continues to provide the public with inaccurate and misleading information about whom they have available to provide mental health care. For example, 23 of 34 psychiatrists on Magellan's referral list for two major metropolitan areas were no longer in network or otherwise unavailable, and only four of those listed actually taking plan members (Geyelin, 2001). The list of participating psychologists and psychiatrists in ten networks serving two counties in New Jersey was shown to be

inaccurate (Holstein, 2004). The network of Magellan Health for Horizon Blue Cross/Blue Shield managed care plans ostensibly served over 150,000 covered lives at the time. Additions of state, municipal, education employees and retirees around the time of the study swelled that number considerably. Yet the panel listing included a psychologist who was deceased 15 years prior to the study and one who had moved out of the area 7 years before the study.

When psychologists and consumers are provided false information about on-panel practitioners, this could quite simply prove to be dangerous for psychologist and patient alike (Holstein, 2002).

These examples are not merely "mistakes," but likely represent a pattern of deception. Ask independently practicing psychologists about their experiences making good faith efforts to resign from networks, to remove their names incorrectly published in print or online, or to prevent being gobbled up by contracts bought within contracts within contracts by managed care entities with whom they never intended to work.

Fontana *et al.* (2007) recently reported that nearly 2/3 of psychologist members of the New York State Psychological Association report they have resigned from managed care panels in the past 10 years, with 6% having resigned from 6 to 10 panels. Eighty-six percent reported "fee too low" as the reason they resigned, the only reason given by more than half of the respondents. Yet more than half had received calls from prospective patients covered by the panels from which they had resigned, patients who had been given their names from plan customer service representatives, who had found them listed in the plans' printed or online directories, or from subscribers who reported they could not find a psychologist in the plan who was taking new patients.

However, the most substantial and challenging to document problem with phantom networks are not the deceased, moved, or otherwise inaccurately listed psychologists, but rather those who are listed and unavailable with full practices. Company health benefits managers and employee-consumers for whom policies are purchased are quite simply purchasing or having these products administered under false pretenses.

Consider that there are many places in the country where this problem exists, and that this exists not just for psychologists but for other healthcare specialists as well, including emergency care. Consider that it is not uncommon for a person with managed care insurance to need specialty care that is hard to find even if one is looking with an indemnity policy. An example would be a child with reactive attachment disorder, or an adolescent with a serious eating disorder. When networks are insufficient and "out of network" psychologists or others are required, cost-shifting moves into high gear and the consumer pays, or the practitioner goes under- or uncompensated.

It has been well-documented that mental health benefits are suppressed by the insurance industry substantially beyond any decrease in other health care benefits. One well-known example, the “Hay report,” documented "The total value of employer provided health care benefits, in constant dollars, decreased by 14.2 percent over the last eleven years. The value of general health care benefits decreased by 11.5 percent since 1988, while the value of behavioral health care benefits decreased by 54.7 percent. As a proportion of the total health care costs, behavioral health care benefits decreased from 6.1 percent in 1988 to 3.2 percent in 1998" (Hay Group, 1999).

Recent surveys by professional groups have shown the importance practicing psychologists place on solving the problems in reimbursement. The American Psychological Association Practice Organization (APAPO) reported in January that 78% of those paying the “special assessment” for practitioners are in full- or part-time independent practice, and that “....insurance and managed-care company practices and reimbursement levels” were among concerns rated “important” (Nordal, 2009). In the context of successes in influencing reasonable reimbursement under Medicare, the APAPO itself has stated, "Seeking appropriate reimbursement levels for psychological services is a top advocacy priority for the APA Practice Organization” (APAPO, 2008). Recent surveys by the New York State Psychological Association of their membership, and a recent survey of independently practicing psychologists show concern about reimbursement to be among the top, if not the top concern. For example, in a March 2009 survey of members of APA’s Division 42 (Psychologists in Independent Practice), 93% “strongly agreed” that “One of the critical issues for APA to address in health care reform discussions is: reasonable compensation for psychotherapy in private practice.” Ninety-five percent agreed that “Inadequate reimbursement for psychotherapy is the top concern for practicing psychologists,” and 71% identified “reasonable compensation for psychotherapy in private practice” as the top priority for APA to address during health care reform discussions.

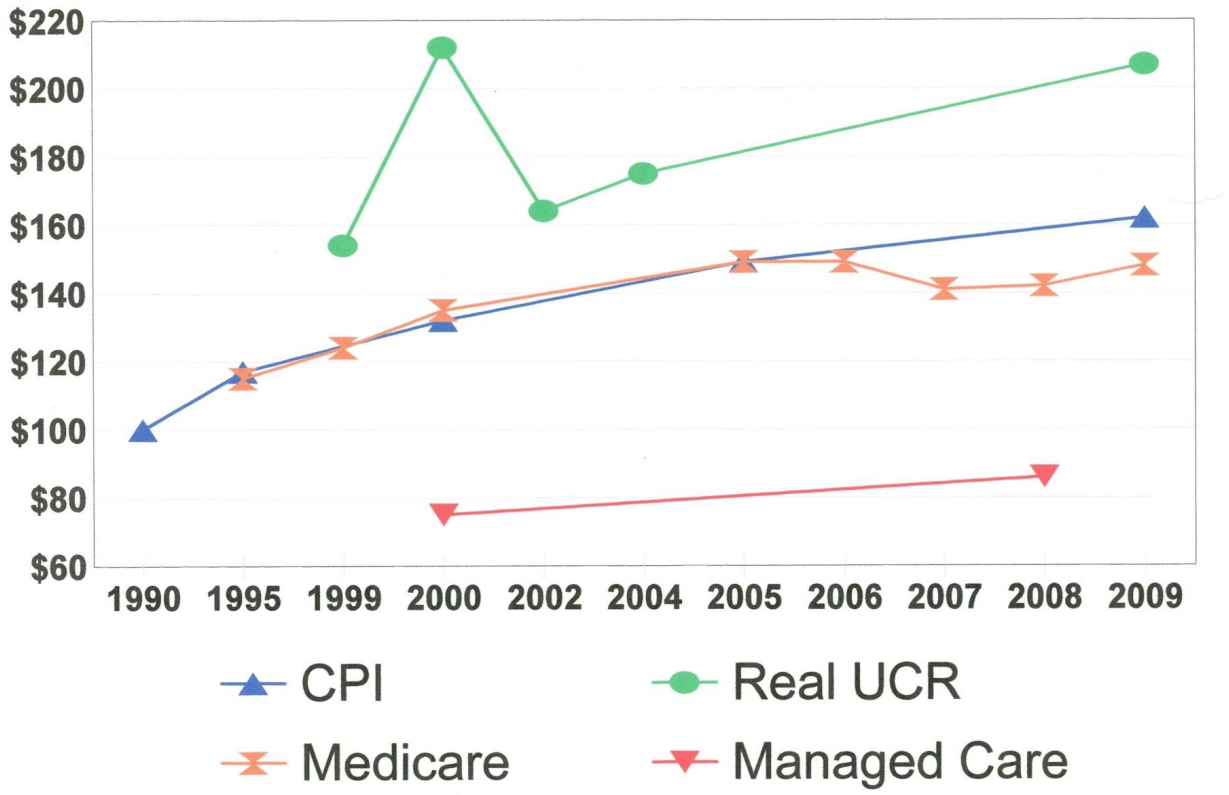
Even if psychological care becomes fully integrated into the health care system, these psychologists represent a large number whose interests remain in providing services which the public demands on an independent basis affording maximum privacy for the patient, and having those services fairly compensated. Full integration of psychological service delivery with the health care system will fail unless services are adequately reimbursed in hospitals, physicians’ offices and other traditional and nontraditional health care settings.

The trends in reimbursement are clear. For example, based on one of the largest available data bases of fees submitted and reported, the 50th percentile of a true “usual and customary” rate billed for an initial diagnostic evaluation interview across the country is $207 (Practice Management Information Corporation [PMIC], 2009, see Figure 1). As a comparison, a charge of $100 for this service in 1990 would be valued at $162 today, based on increases in the consumer price index. Reimbursement through Medicare actually tracks very closely to that estimate, with a 2009 rate of $148 in the Midwest (varying by approximately +/- 1.5% depending on geographic region). In

contrast, managed insurers reimbursed $86 for the same procedure in 2008 (CarePaths, Inc., 2008). While the consumer price index shows an increase of about 25% between 2000 and 2008, reimbursement for an initial mental health diagnostic evaluation may have increased by about 15%, from $75 to $86, during that same time period.

Figure 1

Managed Care Reimbursement for Evaluation Interview
Compared to Changes in Consumer Price Index (CPI),
Actual Charges Submitted ("Real UCR"), and Medicare

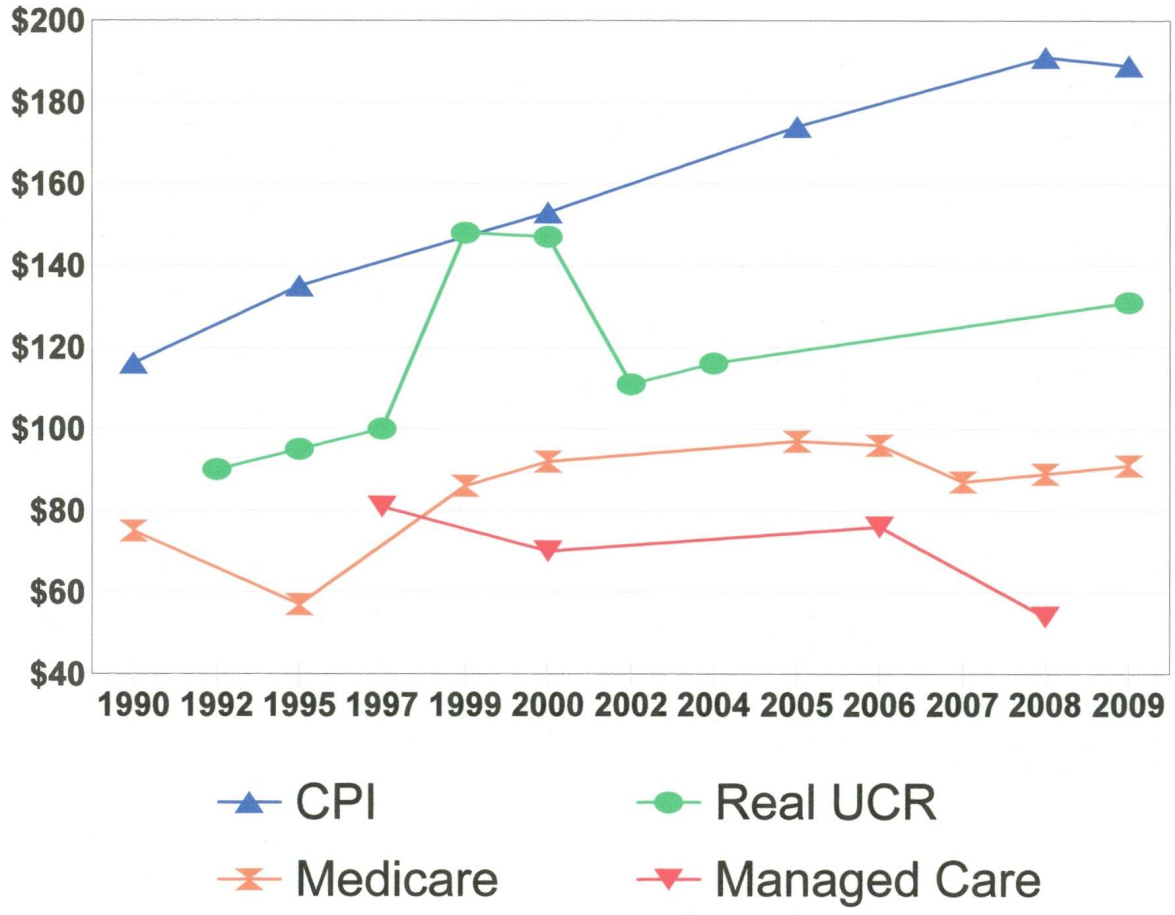


Given what is known about increases in health care premiums, increases in out-of-pocket expenses for consumers, and increases in the overall costs of health care, it is clear that reimbursement to evaluate a person with a mental health diagnosis continues to be artificially suppressed in the managed care environment, even in relation to cost-contained increases seen in the public sector.

The same is occurring for the reimbursement for doctoral provision of psychotherapy (see Figure 2). Ten years ago, actual UCR was $148 for psychotherapy (PMIC, 1999). Based on that value, the consumer price index estimates the value would have peaked at about $191 in 2008 dollars, an increase of about 29%. During the same time period, reimbursement for psychotherapy decreased by 6 to 14%, possibly as much as 33%, if figures for 2008 – reflecting almost 15,000 actual claims paid – are representative (CarePaths, Inc., 2008).

Figure 2

Managed Care Reimbursement for 45-50 Minute Psychotherapy
Compared to Changes in Consumer Price Index (CPI),
Actual Charges Submitted (Real UCR), and Medicare



In the context of increasing premiums and increasing consumer out-of-pocket expenses, where is that money going? Certainly not into mental health care. Nor is it going into increased access to psychologists when consumers want to talk to a psychologist.

Similar data need to be developed regarding other key psychological services such as family therapy, psychodiagnostic and neuropsychological testing, behavioral health treatment, and psychopharmacologic management by duly licensed prescribing psychologists. It is highly likely the data will show commensurate artificial suppression in reimbursement for psychologists' provision of these services, with the associated reduction in access by the public to such services this causes.

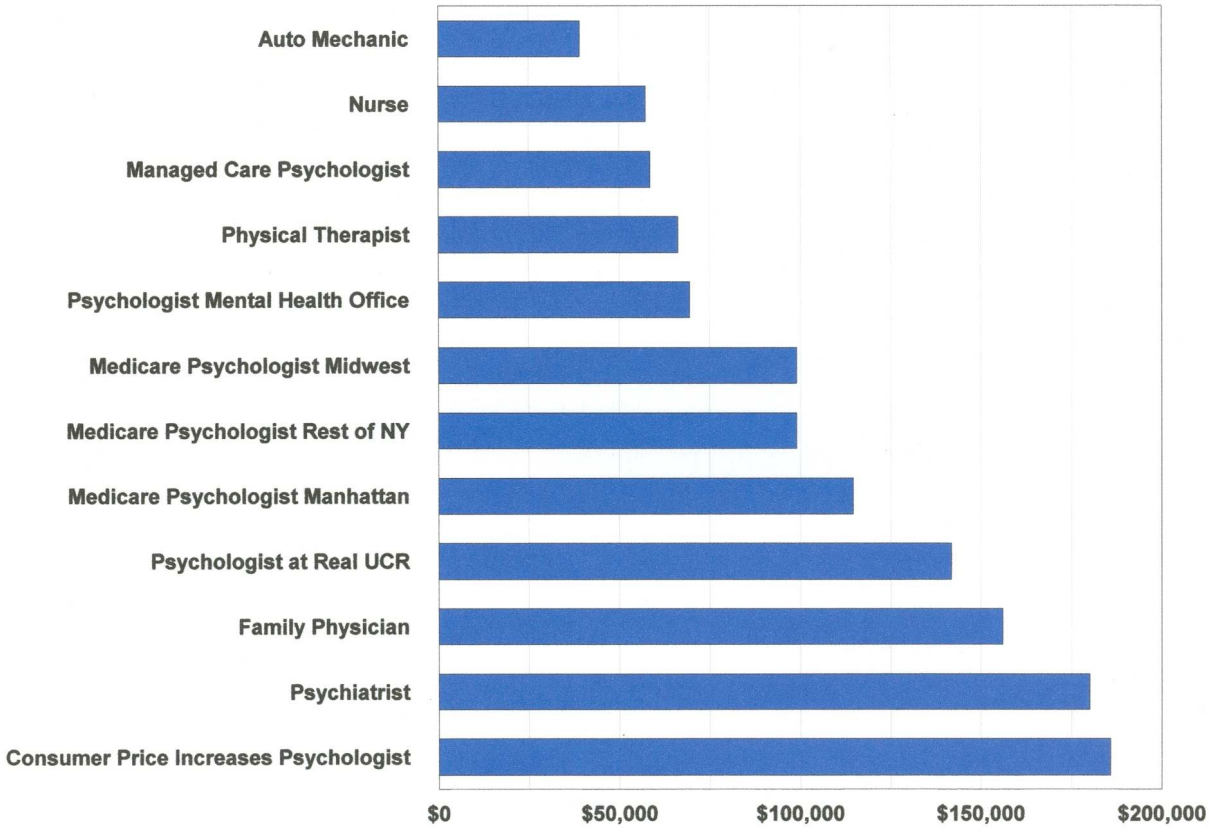
An additional indication of the effects the artificial suppression of reimbursement for psychological services has on recent past and likely future viability of the independent provision of such services is a comparison of psychologist income with that of other professions, under various reimbursement sources. For example, assuming a practice of four new and twenty-five ongoing patients per week, working a 48-week year in an independent setting with 28% overhead costs, a psychologist with a fully "managed care" practice could anticipate a gross income of $58,500 (see Figure 3). This may be compared to income for the most recent year reported by the Bureau of Labor Statistics for physical therapists of $66,200, nurses of $57,280, auto mechanics of $39,200, carpenters at $36,200, social work mental health therapists at $35,400 and marriage and family therapists at $34,700.

Compare the $58,500 estimated gross income in a managed care practice to a psychologist with a similar practice though with a fully "Medicare" based level of reimbursement. A "Medicare-only" practice would yield an estimated gross income of $99,100 in 2009 in New York outside Manhattan and other near-New York City boroughs. Lest the reader think that figure is inflated, the $99,100 estimate for a Medicare-based practice is identical, for example, to Wisconsin figures, and will vary by no more than about +/- 1.5% across the country depending geographic location. These figures may additionally be compared to the level of reimbursement independently practicing psychologists would have attained had rates kept up with ordinary consumer price index changes ("CPI" on the Figure 3 graph) – $185,700 – or <u>real</u> "usual and customary charges" submitted by psychologists (not those falsely reported or secretly held by the insurance industry): $142,000.

With actual reimbursement as it is under "managed care" schemes, one wonders how the current generation of independently practicing psychologists can survive, much less the future generation currently in training and beyond.

Figure 3

Income Estimates, Psychologist Under Fully Managed Care Reimbursement, Compared to Medicare Psychologist, Consumer Price Index Increases, Real UCR and Other Occupations



"Parity" is not the solution: Psychological care occurs in an artificially controlled market

The history of the fight for parity demonstrates both the reluctance of the insurance industry to adequately fund mental health services and the growing desire of the American people to have mental health services available. In October 2008, the federal parity bill finally passed Congress and was signed by the President. This federal legislative achievement came after most states already had some form of parity. With the federal legislation, in most ways, it appears parity has won the battle, and that in the future, mental health services will not be discriminated against on the basis of copayments, deductibles, and caps on expenses.

While parity has been achieved, it is by no means the end of the resistance by the insurance industry to adequately fund mental health services. Clinicians around the country are struggling to keep their practices open or leaving the field due to reimbursement levels that remain essentially flat or are declining in real dollars.

In the U.S. health care systems, reimbursements do not respond to the demands of the marketplace as they would in a typical marketplace. Instead of normal market forces, government and managed care entities have the major influence on reimbursements. These organizations can create shortages of professionals in areas where there may be

extensive consumer demand. The current examples are primary care physicians, nurses and psychologists.

Experience in health care reform work through study of the literature, contacts with policymakers, and contacts with health care reform activists including consumers and professionals reveals a general awareness that the health care system is not reimbursing primary care physicians or nurses adequately, while there is essentially no awareness of the problem in reimbursement for psychologists. Even among mental health advocates, the entirety of the message typically emphasizes the need for inclusion of coverage for mental health conditions and the need for parity. Moreover, the awareness of problems with reimbursement among other health professionals does appear to yield a process resulting in remedies. When health care reform is seriously discussed, and in most reform proposals, there are recommendations for addressing the problems of low reimbursements for primary care physicians and nurses.

Historically, mental health advocates believed that managed care issues needed to be subordinated to achieving parity, and even if the parity included a toxic amount of managed care, we should achieve parity first, and then fight the other battles. Since the early 1990s, managed behavioral health care companies have been allied with mental health advocacy groups in the parity campaign. This is reminiscent of the tobacco industry joining the fight for smoking cessation. In maintaining this alliance, parity proposals have generally contained few restrictions on the actions of managed care entities. Even the current federal parity law allows elimination of mental health benefits entirely, or management of benefits based on other rules with the policy. It is probable that this alliance has hampered efforts to include adequate reimbursement for mental health services in discussions of parity. The exclusive emphasis on parity has now created a situation in which managed care decreased reimbursements have become the primary threat to the delivery of mental health services.

The proper way to describe the problem is that there is discrimination against all forms of mental health services – except perhaps dispensing psychotropic medications, though even this is provided by primary care physicians and not specialists – and that it is not just isolated discrimination against access to psychologists. As the above salary figures for social workers and counselors, as well as their reimbursement levels, which are considerably below psychologists, demonstrate, most mental health professionals

are paid poorly. The only exception seems to be psychiatrists, which might be a result of a national psychiatrist shortage. As mental health services are underfunded, there is also inadequate staffing at mental health centers, clinics, training programs, and other settings in which psychological services should be available.

Mental health is more adversely discriminated against by insurance and managed care entities than physical health care

The Lewin Group analysis prepared for the Colorado Blue Ribbon Commission for Health Care Reform analyzed payment data in Colorado. On page 15 of "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System" typical cost shifting in hospital payments was documented as follows: insurance companies paid 131%, Medicare paid 75%, and Medicaid paid 65% of the actual costs of providing services. In other words, in hospital care, insurance companies tend to pay more than public payers. In mental health care, there is a different pattern. While Medicaid often pays too little to employ psychologists, Medicare pays more than most insurance companies. This points to an issue in mental health; insurance companies are more aggressive in reducing mental health reimbursement than they are in reducing medical reimbursements.

Solutions

The following three key areas of action are recommended.

1. <u>Conduct comprehensive, nationwide research regarding insurance industry practices</u> including
    a. Actual reimbursement data, trends over the past 25 years, and projected trends for the next quarter century
    b. The difference between actual psychologists' charges, reasonable costs required to maintain a viable independent practice industry, and the insurance industry's definition of "usual and customary"
    c. The impact actual reimbursement has had on the independent practice of psychology
    d. Numbers of psychologists remaining in and leaving managed care settings
    e. The public's preferences for ways to access psychological services
    f. The impact these factors have the public's ability to choose and access psychological services

Fragmented data in these areas are available. Only a comprehensive, nationwide overview of such information will provide a meaningful understanding of the state of the insurance industry and its impact on psychological practice and public access. Our national organizations, or entities specifically constructed, funded and hired by our national professional organizations, are in the best – perhaps only – position to conduct

such integrated and comprehensive research. Our national organizations must create ways to conduct such research even in the context of the "antitrust problem" and other organizational structural challenges.

2. Develop and implement a nationwide, "evidence-based" public education campaign based on the data acquired about current reimbursement mechanisms and their impact on the health of psychological practice and patient choice and access to psychological services.
    a. "Public education" should be taken to mean education of
        i. Consumer advocacy groups which emphasize mental health care
        ii. Business entities and benefits managers who purchase health benefits packages for their employees including emphasis on
            (1) Obstacles to access to psychological services for their workforces and its relationship to the reduced health and wellness of employees
            (2) Limitations in an "EAP"-only/brief mental health benefit in supporting the health and wellness of employees
        iii. Legislators who are in the process of crafting national health and health financing reform
        iv. Allying with health professionals who are under similar reimbursement pressures which impair their ability to continue to maintain viable practices and limit public access to their care
    b. Methods could include
        i. Live, online or other conferences with insurance commissioners to apprise them of issues psychologists encounter in their States
        ii. Meeting with the Attorney General Organization to inform them of related issues
        iii. Working with our APA public relations department to create a series of articles nationally addressing some of these issues in a more systematic fashion

3. Actively design and influence the structure of the future version of our health care delivery and health care financing system.
    a. Organized psychology must take a position that "managed" reimbursement schemes clearly have damaged the psychological and behavioral health of our citizens and communities, and impaired the viable provision of psychological services that citizens want.
    b. Organized psychology must take the position that such mechanisms have no place in a reformed health care and health care financing system, and
    c. Offer viable alternatives to psychological health care financing and service delivery including
        i. Scholarly examination of proposals currently in the pipeline
            (1) This should include proposals put forward by psychologists (Herz, 2003; Miller, 2003, 2006; Rudy, 2003; Shore, 2000, 2005)

ii. Making a decision about the specific model to support
iii. Vigorously supporting that model with all available resources

Our national organizations must create ways to engage in such "evidence-based" political advocacy in the public interest even in the context of our scientific and educational and mandates and eleemosynary impulses.

An important question is, what are the best ways to systematically accrue information about managed care/insurance company practices that are detrimental to patients and the independent practice of psychology and to systematically involve the APA and its related organizations to intervene in those bad practices? The following are suggestions for information that is needed which should be collected systematically.

1. More information about insurance reimbursement for the "Health and Behavior" CPT codes including
   a. More information on reimbursement rates for the health and behavior codes; specifically, are they at least equal to the Medicare rates?

2. In light of recent (e.g., Leichsenring & Rabung, 2008) and prior research demonstrating the efficacy of psychodynamic therapy with chronic illness, which companies are preventing this more intensive care for the severely affected?
   a. Which companies are preventing ongoing services by claiming that they do not reimburse for care of individuals with chronic conditions?
   b. In view of the new parity law, can insurance companies refuse to reimburse for care of chronic mental illness? Further, are there inconsistencies in reimbursement among diagnoses? For example, reimbursement may be available for chronic care of persons with schizophrenia, but not for severe and continuing anxiety or depressive disorders.
   c. If discriminatory patterns of reimbursement are identified, our national organizations should intervene with litigation if necessary or with other methods

3. What inconsistencies are there in the payment for psychological testing? In many cases, managed care/insurance companies have claimed that they will not pay for testing (with all sorts of special permissions required) based on many rationalizations including its ostensible unreliability. Yet other insurers are heartily endorsing psychological evaluations for specific conditions – perhaps when costly treatment may be denied on a psychological basis – such as prior to bariatric surgery.

4. Which managed care insurance companies are refusing to reimburse medical/prescribing psychologists for their psychotropic intervention?
   a. Are the reimbursement rates for the medical/prescribing psychologists in any way commensurate with their level of training and service, i.e.,

commensurate with other doctoral practitioners who prescribe psychotropic medications?

What are the most efficient and most organized way to accrue such information?

1. Obtain a representative sample through the questionnaire methodology being developed by and tested in Georgia and New York
2. Conduct sampling online via professional development demonstration projects through APA's Practice Directorate
3. Gain a broader cross section and, in the process, help members feel more listened to, by providing a funded Ombudsperson to respond to calls in "real time" and consistently and systematically document and publicize concerns
4. Integrate efforts that are ongoing, such as
    a. The questionnaire being developed and field-tested through the APAPO Office of Legal & Regulatory Affairs
    b. Integrating communications such as email lists for psychologists around the country who are concerned about managed care and other insurance industry issues
    c. Activities of the Interdivisional (39/42) Task Force on Managed Care and Health Care Policy and
    d. Similar efforts among state psychological associations and divisions

What structures at the APA level need to be in place to enact this more organized, broad-based approach?

1. Allocation of existing and continuing staff to accomplish these tasks
2. Creation of a National Ombudsperson position skilled in both psychology and advocacy
    a. This position could be jointly funded by uniting funds from CAPP and divisions most concerned about managed care, such as Divisions of Independent Practice, Health Psychology, Psychoanalysis and other "practice" divisions

Collecting and disseminating fee information in the context of the "antitrust problem"

It is possible and necessary to take a straightforward interpretation of the "antitrust problem" and how this affects what our professional organizations can and cannot do to address inadequate reimbursement for psychologists' services. A straightforward understanding will provide the widest latitude for actions that psychologists, individually and collectively, and our organizations, could be taking.

The APAPO has itself previously published information in just this area (e.g., “Getting paid: Responding to managed care rate cuts -- A practical guide for psychologists,” especially, “Acting in light of antitrust law" (APAPO, 2007). Fundamentally, the "antitrust problem" means that there are two things psychologists cannot do **as a group**: (1) collectively set rates with other psychologists who are "competitors," and (2) threaten to or engage in a boycott of specific companies in an attempt to influence rates. This means that many other individual and group actions are available. Based on this understanding, APA and APAPO potentially could be engaged in activities such as:

1. APA can **educate the public** about
   a. Insurance industry and government reimbursement effects on the practice of psychology and
   b. Related issues of public choice and access to psychological care
   c. One of the reasons that primary care providers are paid poorly is that they, like psychologists, spend much of their professional time in the cognitive aspects of care: talking, listening, and thinking about patients. The for-profit health care financing system does not want to reimburse for such activities. The specialties which perform "procedures" are reimbursed much better, and can make money by becoming like technicians who do procedures faster. Do we want a system in which the provider who works the quickest, talks and listens the least, and does not take time to think, is the one who makes the most? This is not the health care system psychologists or consumers want.

2. APA has long found that it was permissible to advocate for parity. Now we have achieved "pretend parity." In the tradition of the last 20 years of advocating for parity, APA can expose "pretend parity" and advocate for changing it. It can conduct research and educate the public about:
   a. How “pre-authorization,” “reauthorization,” “outpatient treatment reports,” and similar onerous paperwork burdens are among the barriers to real parity which the insurance industry will continue to erect, to harass psychologists, and undermine psychologists’ services, limit access, limit “medical loss,” and maximize profits
   b. How mental health is treated differently than physical health because of such unique obstacles to obtaining treatment. Federal parity legislation will not limit this sort of discrimination.
   c. How requirements to tell insurance companies about personal information discourages patients from seeking treatment, and the essential requirement of privacy in the psychotherapy relationship.
   d. How mental health is treated differently than physical health care when periodic adjustments in reimbursements are considered, e.g., in physical health care, there are regular adjustments and in mental health care there is no attempt to maintain reasonable reimbursement

e. How low managed care reimbursements are forcing psychologists to develop ways to make a living other than treating patients. As in primary care medical care, the best and brightest are choosing other training and work or are leaving the profession because of this kind of damage to the profession.
f. How limited provider panels discourage patients from seeking or therapy or having access.
g. How limited reimbursements or limited "reasonable and customary" rates undermine out-of-network coverage, increase patient costs, and limit choice and access.

h. The hidden negotiation behind the scene in which insurance companies determine the length of stay for inpatient treatment.

All of these research and public education activities would appear to fall well within an antitrust “safety zone.”

In addition, comprehensive data collection could be used to educate business and industry and purchasers of health care policies about

1. Effects on the health and wellness of employees and the workforce in the context of barriers to psychological health care due to
   a. Continued disparity in the “management” of and intrusions into the psychologist-patient relationship compared to the physical-health practitioner-patient relationship
   b. Excessive costs in insurance policies due to unnecessary administrative costs and excess profits.
   c. False and exaggerated claims by the insurance industry to purchasers and managers of workforce health care policies about numbers of psychologists available and actual benefits provided.

In the context of the “antitrust problem,” our national organizations must create ways to obtain a broad view of psychologists’ actual experiences with specific managed care and insurance companies, and disseminate this information to the public, to governmental and regulatory agencies, and to business purchasers of employee health care coverage. This can and must be done. As an example, observe the American Medical Association’s report cards on insurance companies (see http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/heal-claims-process/national-health-insurer-report-card.shtml). Such efforts would serve a public education function, a public health financing and quality control function, with a necessary secondary effect of ensuring a vibrant mental health industry supporting the independent provision of psychological services.

To accomplish these objectives our national professional organizations must undergo a fundamental shift in the way the “problem” is defined, and solved.

We need to direct our organizations’ legal and policy thinkers to identify ways to address the number one underlying threat to current and future public access to psychological care: inadequate funding and reimbursement. Until this problem is addressed and solved, efforts to fully integrate psychological services into the broader health care system will fail.

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