Psychotherapy and the Perfect Storm of Change

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The author surveys the many forces of change that will have an impact on the practice of psychotherapy in coming years. These include parity, health care reform, federal and state deficits, electronic health records, evidence-based medicine, pay-for-performance, reimbursement issues, and attacks on fee-for-service medicine. Vulnerable aspects of psychotherapy are privacy and confidentiality, individualization and choice of therapy, access to therapy, therapist’s choice about participation, denial of coverage based on diagnosis, and sufficient payments to sustain practice. Psychiatric workforce issues may compound the effects. The author identifies some issues calling for vigilance, advocacy, and defense of the key values of psychotherapy and the environment for providing it. (Journal of Psychiatric Practice 2009;15:408–414)

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Psychotherapy is an intensely personal experience. No matter what variety of psychotherapy is involved, it is sheltered by confidentiality, a high level of privilege in court proceedings, and the commitment to ethical behavior on the therapist’s part. The therapist-patient relationship is the foundation for psychotherapeutic work and, in the more psychodynamically oriented approaches, it is central to the treatment process. Although each therapeutic method has its own intrinsic structure, the way in which this is implemented has to be tailored to each individual patient according to a detailed diagnostic profile as well as the patient’s personality, age, gender, physical health, and matrix of relationships. Characteristics of the therapist also enter the equation. Patients and therapists decide together what approach best suits the patient, which may vary considerably from case to case.

Small wonder, then, that psychotherapists look with apprehension on the converging forces of change that could threaten the protected and personalized environment in which they work. I am reminded of the legendary “perfect storm,” a rare situation in which multiple severe weather patterns converge to create enormous violence and destruction. In the present convergence of changes, of course, the possibilities are not so likely to be catastrophic. In fact, most could be beneficial to patients and therapists alike. However, uncertainty and the exaggerated, dire predictions of some opponents create an atmosphere of anxiety and apprehension. In this column, I try to sort out the multiple sources of tumult in the health care system and think through with you how they might affect the work we value so highly.

The following aspects of therapy appear to be most vulnerable:
- Privacy and confidentiality
- Individualization and choice of therapy on the part of patient and therapist
- Patient access to psychotherapy
- Free choice about participation in third-party payment plans as a provider
- Inclusion of psychotherapy or of the conditions for which it is most helpful in insurance coverage
- Payment levels sufficient to reverse the current strong economic disincentives for psychiatrists and other professionals to provide psychotherapy.

The converging elements of the “perfect storm” include the following:
- Purity bills already in the process of being implemented
- Health care systems reform, especially the proposed “public option”
- The ballooning federal deficit and desperately underfunded state governments during a severe recession.
- Electronic health records

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Parity

After decades of advocacy and lobbying, Congress has passed two pieces of legislation that require insurance coverage for mental disorders, including substance use disorders, that is on a par with benefits for other medical conditions. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires parity in coverage for mental disorders in private health insurance provided by employers with 50 or more employees as of January 1, 2010, if the plan covers mental disorders at all. Because the legislation leaves it to the insurance companies to determine what qualifies as mental illness for these purposes, the risk to psychotherapy lies in the possibility that an insurer could limit coverage to the treatment of the more severely ill, for whom psychotherapy tends to be considered adjunctive to somatic treatments if it is offered at all. However, the most common disorders in the workplace are depression, anxiety disorders, and substance use disorders, for the treatment of which psychotherapy plays an important role, and employers know this. (It is important for advocacy purposes to know that employers finance and hence ultimately control around half of the health care economy.)

An employer whose costs increase by more than 2% as a result of implementing parity could opt out of covering mental disorders for 1 year following the year in which this cost increase occurs. Fortunately, employers and their benefits consultants seem to have caught the message, actively presented by the APA’s Business Initiative among others, that strong evidence now indicates that it is in employers’ best interests, from a cost perspective, to support early and effective treatment of mental disorders, including substance use disorders. However, we can expect that psychiatric treatment in employer-sponsored health plans will be aggressively managed, which presents threats to privacy, access to and choice of therapist, selection of therapy, and sufficient duration and intensity of psychotherapy to achieve the desired results. Advocating for out-of-network coverage will be important, since many mental health professionals have given up on belonging to insurance panels.

Another bill also passed in 2008 eliminates the so-called “psychiatric reduction” in Medicare that effectively results in patients paying 50% of the fees for outpatient psychotherapy instead of the 20% copayment for other outpatient medical services. This correction will be phased in very gradually over a cruelly long 4 more years until parity is reached in 2014. It begins with raising coverage to 55% in 2010. This discrimination has existed since the start of Medicare in 1964 and is functionally compounded by de facto discrimination against less well off patients who don’t have supplemental insurance to pick up the 50% copayment. Aside from the protracted phase-in period, it’s hard to see a downside to this change, which will make it possible for many more seniors or disabled people with lower incomes to have affordable access to psychotherapy.

In my experience, there is no administrative hassle in dealing with Medicare, even for intensive psychotherapy or psychoanalysis, and the HIPAA protection of psychotherapy notes is respected. Bills submitted electronically are paid punctually in 19 days with the supplemental payments coming a few weeks later. The fees are lower than the going rates for self-paying patients, but not as low as what patients or I collect from private carriers in my region as an out-of-network clinician. Medicare fees will increase by 3% next year for psychiatric services overall, but they are perennially threatened with major slashes due to the dysfunctional “sustainable growth rate” formula, which have been overridden by Congress at the last minute year by year. For 2010, the reduction will be 21.5% if Congress fails to act This leads us to health care reform, The leading legislation that has been proposed would restructure the sustainable growth rate formula, prevent cuts to physicians, and provide for further increases for primary care services at the expense of specialties such as cardiology to encourage new physicians to enter primary care.

Health Care Systems Reform

As this is written, health care reform is in a highly volatile state at the center of a fire storm of protests, misrepresentations regarding end-of-life decisions and abortions, and bare-knuckle defense of special
interests. Those who have insurance are very frightened that covering the uninsured will be accomplished at the cost of lowering their benefits and raising their taxes. Based on President Obama’s broad outlines and the leading bill in the House of Representatives, it would appear that many measures to bring the uninsured and underinsured into the insurance system would considerably increase the number of patients who would have access to psychotherapy services.

Thirty-eight mental health organizations have signed a powerful letter calling for full parity for services for mental illness, including substance-use disorders, in the reformed health system. The House has incorporated parity into its bill and removed the exemption for employers with fewer than 50 employees. Parity would be part of the required benefits in a non-profit insurance exchange if that becomes part of the reform. A Senate bill has incorporated parity in a narrower way. It seems likely that parity would be protected at least to the point that would occur without health care systems reform.

A variety of limitations on underwriting would ensure that people would not lose coverage because of factors such as losing their jobs, developing a major illness, changing plans and having a pre-existing condition, being female, or reaching an annual or lifetime limit—a clear movement towards community rating rather than selective underwriting. The bill includes mandates to employers and individuals the intent of which is to get almost everybody into an insurance plan. A major question from the standpoint of cost containment is whether the influx of previously uninsured people would lower the overall loss ratio of the private insurance companies; the newly insured would probably be predominantly a younger cohort, but they would have lacked preventive care or the benefits of early detection of disease so some could be sicker. Another question is whether the insurers’ loss of the ability to shut out higher-cost patients through underwriting would drive up the overall premium level for everyone. The bill would not reduce insurance companies’ 20% or more slice of the premium pie for administration and case management, executive salaries, profits and dividends to shareholders, and legitimate reserves to maintain financial viability, so it is unclear whether major savings to the overall system would occur. In contrast, Medicare operates with approximately 2%–3% direct overhead administrative costs plus an unknown but probably modest indirect expense through the budgets of the federal oversight agencies. This is a powerful argument for government-based health care, or “Medicare for all.”

A Public Option

At present, there is serious doubt that a public option, the cornerstone of the Obama plan, will survive the political turmoil. Advocates of universal, single-payer, national health insurance are offering an alternate bill for such a system, but ultimately they seem to be resigned to supporting the public plan as a strictly optional, competitive alternative to private health insurance. Not burdened by the 20%–30% overhead of private insurance, it could be a field for creative approaches to health care delivery and financing. In practice, it would probably draw more people who are currently uninsured, self-insured in small businesses, or trying to find affordable coverage in the current prohibitively priced individual market. Critics say it would force people to change insurance because it could encourage businesses to stop offering health insurance since employees would have an alternative. (In the recession, some employers are already dropping or drastically reducing their contribution to health insurance for employees without a reasonable alternative being available.)

The case for a public option, combined with a proposal for a proactive study to compare the competing systems, is well presented by the following statement signed by 59 members of the Harvard Medical School Class of 1959. (Full disclosure: I was one of the four HMS ‘59 types who drafted it.)

“The Urgent Need for National Health Care Reform

Fifty-nine members of the Harvard Medical School Class of 1959 are convinced that reform of the American health care system is essential, must be substantial and carefully designed, and must include a public health insurance option.

We present our position in this statement, a result of intense discussions begun at our June reunion commemorating 50 years since graduation. We are a majority of our 112 living American classmates. Six declined to sign the statement because they disagree with it, 3 more because it is not detailed enough, and 44 expressed no opinion.

Each of the signers has 50 years of experience and leadership in clinical practice, medical education,
administration, and/or research. Our collective careers cover a wide variety of primary care and specialty fields in a range of organizational settings, in both private practice and academia, across the United States.

We believe that our humane and enlightened country, committed to ‘life, liberty and the pursuit of happiness,’ has the obligation to provide everyone with the opportunity to obtain affordable insurance and quality health care.

We support President Obama’s proposal that all citizens should be offered the option of a government-sponsored medical insurance plan, along with private options. In our opinion, health care reform will fail without the discipline of competition from a public option.

Excluding a public option would throw away a vital opportunity to test different ways to provide quality care for all. A public plan would help develop and evaluate new standards of practice, malpractice reform, and reimbursement of physicians, and would emphasize preventive care. To be affordable, it would have to avoid financial incentives for unnecessary services and contain measures that curb financial abuse and waste by some hospitals and, unfortunately, by some of our medical colleagues.

A public option would also identify and encourage use of demonstrated best practices shown to be effective at less cost, offer greater access, and provide higher quality of care. Administrative overhead, as now in Medicare, would be significantly lower without for-profit intermediaries. These innovations could help lift the competitive burden that health care places on American employers in the global marketplace, while also offering portability and continuity of coverage during job changes and illness.

Common sense demands a planned, full comparison of the relative benefits of public vs. private options. At the outset, there must be clear and uniform ground rules for measuring, reporting, and evaluating cost, access, and quality of care for all plans.

We urge Congress and the President to take this courageous step at a vital time in our nation’s history."

How a public option would affect access to psychotherapy is unknown because the structure of a public option has yet to be designed. My best guess is that it could resemble Medicare, with somewhat higher pay scales to induce providers to participate. Other cost-saving devices, to be discussed in the remainder of this column, could have a heavy impact on psychotherapy. Their effects could remind us of the adage, “Be careful what you wish for.”

Psychiatric Workforce Issues

When facing a perfect storm, it’s a disadvantage if the boat leaks and is underpowered. That may be an apt metaphor for psychiatry, especially for the psychotherapeutic dimension of biopsychosocial practice. If health care reform succeeds in accomplishing its goals, there will be a surge of new patients coming from the ranks of the presently uninsured. They may be young, unemployed or poorly paid, or medically underserved, some of whom will surely be in need of care for mental disorders including substance use disorders. There is already a shortage of psychiatrists, especially child and adolescent psychiatrists whose patients have so many developmental and family issues that desperately call for psychotherapy. The psychiatric workforce now includes many whose training and experience in conducting psychotherapy are considerably less than the older generation. The current emphasis on neurobiological processes and treatments, coupled with managed care minimalism and poor reimbursement of psychiatrists for psychotherapy, has driven a trend towards markedly reduced conduct of psychotherapy by office-based psychiatrists. They can earn a much more substantial living by doing medication management in three or four brief visits in an hour than by providing a psychotherapy session. Either in multi-professional group practices or in managed care networks there is a tendency to divide psychotherapy by non-medical clinicians from medication management by psychiatrists, with or without coordination of care. This deprives patients of integrated treatment by a psychiatric physician skilled in the full range of what psychiatry has to offer.

These sobering developments occur as the evidence mounts that the various psychotherapies are effective and valuable treatments with lasting results. The psychiatric profession, both through its organizations and through individual contacts with Senators and Representatives, must advocate for appropriate and equitable payment for psychotherapy by psychiatrists. To close the gap in training and experience, psychotherapy training of residents must have a high priority (as many residency directors already have come to recognize). Practicing psychiatrists can build
or brush up their skills through continuing education programs and/or obtaining supervision. For many that experience would feel like welcome enrichment and reinvigoration of satisfying clinical work.

The Deficit, the Recession, and the Price of Doing Nothing

President Obama inherited an enormous deficit due to the legacies of the Bush regime—two drawn-out wars and large tax cuts. It has been compounded by the recession-fighting bailouts of the banks and auto companies followed by the stimulus package. The Congressional Budget Office has placed the cost of the health care reform bill at close to a trillion dollars, despite President Obama’s expectation that the bill could be revenue neutral over a period of 10 years. He proposes to achieve this through elimination of waste, fraud, and abuse in Medicare; by cutbacks in costly subsidies to Medicare Advantage plans offered by private insurance plans in the Republican effort to privatize Medicare; and by measures to provide more efficient and effective health care, some of which will be discussed below. The same political coteries that didn’t blink at the ballooning deficits created by questionable wars and tax cuts are now vociferously objecting to further increases in the deficit to provide health care for almost all of the population. There is serious question whether meaningful reform will occur at all in this session of Congress, despite the White House and the Congress being dominated by the party that advocates for reform.

Yet the price of doing nothing is continued steep increases in the costs of an inefficient and inequitable health care system that burdens the national and state governments, puts American industry at a serious disadvantage in the global economy because it has to provide health insurance benefits, and causes neglected health needs, economic distress, foreclosures on home mortgages, or bankruptcy for individual citizens. Needless to say, access to psychotherapy is severely limited for many people under the current system and will remain so in the absence of health care reform.

The Hopes for Enhanced Quality at Lower Cost

“Evidence-based medicine.” The foremost aim of evidence-based medicine is to use scientific research to determine what really works for whom (to paraphrase Roth and Fonagy’s review on the subject as applied to psychotherapy) and to devise recommendations for best practices. I discussed the application of evidence-based medicine to psychotherapy in detail in this column in 2002 and so just will touch on the highlights here. The gold standard for evidence is diagnosis-specific research on subjects selected for their purity of diagnosis, who are then treated with a standardized therapy in randomized, controlled, double-blind trials. However, conclusions drawn from such research must be applied to patients in real life with due awareness of ubiquitous comorbidity and the many variables that go into clinical judgment with individual patients, including their own preferences and suitability for specific forms of treatment. There is a growing recognition that measuring effectiveness in real life (i.e., overall improved function and reduction of morbidity) is as important as measuring the efficacy of a treatment in controlling symptoms.

Since 2002, a randomized controlled trial has shown psychodynamic psychotherapy to be extraordinarily effective for panic disorder, showing that high-quality studies of psychodynamic psychotherapy are feasible. New findings have been added to the already impressive literature showing efficacy of cognitive-behavioral therapy and interpersonal psychotherapy for various symptom disorders in pure form. Dialectic behavior therapy and transference-focused psychoanalytic psychotherapies have been shown to be effective for treating borderline personality disorder. Evidence also supports the enhanced value of combining psychotherapy with psychopharmacological treatments.

Less diagnosis-specific therapies may be needed for someone with comorbid conditions, such as the common mix of depression, anxiety disorder, personality disorder, and/or substance use disorder. A recent meta-analysis of 23 studies of long-term psychodynamic psychotherapies (LTPP), including 11 randomized controlled trials, has demonstrated their efficacy for complex, serious psychiatric disorders, with positive results that hold up or even improve further over time. In the author’s words, “LTPP showed significantly higher outcomes in overall effectiveness, target problems, and personality functioning than shorter forms of psychotherapy,” especially for “complex mental disorders.”

A new line of research with intensive psychotherapy, such as psychoanalysis, is to correlate the therapy with brain-imaging studies, bypassing many problems that make efficacy studies of such intense, inti-
mate, lengthy treatments notoriously hard to design. This relates to modern views of plasticity of the brain and reconfiguration of neural networks through intensive experience. We may see results in a few years.

The ultimate caveat in regard to evidence-based medicine is to avoid cookie-cutter approaches that leave no room for individualized decisions about the selection, duration, and intensity of psychotherapy. The prime concern has to be what gets the best results; cost and cost-containment are secondary issues. It is usually most cost-effective to do it right the first time, even if the initial cost is somewhat greater. It is safe to say that the evidence base for psychotherapy is getting stronger and can support the selection of effective treatments.

“Pay-for-performance” reimbursement. It is hard to envision how this method of basing payment on results could be applied to psychotherapy, with the exception of specific symptom-focused treatments such as CBT. How would performance be measured? There is no blood test for depression or anxiety. Symptom scales are subjective and narrowly focused, leaving no way to measure subtle changes or nuances. How can one quantify the degree of insight or capacity to make life changes that a patient might have discovered in the world beyond symptoms? How could subtle changes in personality be measured practically on an ongoing basis outside of a research project, and by whom? Rarely can a single measure capture the complexity of what goes on in a therapy or the stability of change over time. It’s not like tracking blood sugar or blood pressure on a graph. Nor is measuring performance easy with chronic, severe mental illness, where the success of supportive or even insight psychotherapy, combined with promoting adherence to medications, may be the prevention of relapses or restoration of some function. The therapist then has little control over the time factor.

Beyond these considerations is the effect of “pay-for-performance” on transference and counter-transference. It would be hard for therapists to be patient as patients struggle with their resistances to awareness and change. One can envision the glee with which certain patients would embrace that kind of control over the therapist’s paycheck.

Alternatives to fee-for-service payment. Some of my Harvard classmates are convinced that fee-for-service payment systems are the real culprit in escalating health care costs. Here is where waste, fraud, and abuse can be rooted out, they say. Unfortunately a few bad apples can disgrace a system that has functioned for centuries throughout the world—payment to an ethical professional for services rendered. We are aware of the examples that have surfaced over the years. The most recent was a New Yorker exposé of blatant exploitation and medical entrepreneurship in McAllen, Texas, compared with El Paso county, which has the same demographics, and with the Mayo Clinic. What reportedly goes on in that town is a violation of medical ethics pure and simple. The analogue in psychotherapy would be keeping a patient in a fruitless therapy to which he or she is unsuited, just to fill a vacancy in one’s schedule.

Should we all be on salary? All part of an organized system? But well known systems have become exploitative on a grand scale and ended in disgrace. Systems are not a cure-all, and they add layers of bureaucracy, expense, and potential interference with the therapist-patient relationship. However, we know that it is perfectly possible for excellent psychotherapy to occur in settings such as agencies, hospitals, treatment centers, and group practices, where the therapists are on salary.

I cannot imagine anything other than a pluralistic approach across our large and diverse nation, where the structure of health care can be adapted to local conditions and the health problems that are being addressed. The one variable that all can share would be a standard of ethical behavior, whether by individual clinicians or by health care organizations, that is as old as the Hippocratic Oath.

Psychotherapy can be ethically and effectively practiced by independent solo practitioners and by salaried clinicians, so the challenge is to fight for the conditions for doing so, no matter where. Systems must preserve the confidentiality of psychotherapy patients and their trust in their individual or group therapist, while upholding standards of quality and providing opportunities for therapists to consult with each other and improve their skills. Therapists in solo private practice have the same responsibilities to ensure confidentiality and to make the extra effort to consult with other therapists and stay current with their field.

Electronic medical records. It is clear that electronic medical records have enormous potential to
facilitate excellence in health care. Yet, given the enormous expense of creating interchangeable electronic records systems, it is hard to see them as a cost-saving device in the foreseeable future. Simple and inexpensive systems for solo practitioners of psychotherapy must be devised if they are to participate. However, the most dangerous aspect of this systemic advance is the persistent and widely publicized vulnerability of highly sensitive electronic databases to massive thefts of data and invasions of privacy. As the system grapples with this challenge, it is fundamental that psychotherapy notes must retain the full protection accorded them by the 1996 U.S. Supreme Court decision in Jaffee v. Redmond, which is recognized in the HIPAA provision for keeping psychotherapy notes as a separate part of the medical record. Psychiatrists in hospitals and other organized systems must be uncompromising in protecting the right to keep such notes and strictly control any access to them. If there is no way in an electronic records system to keep psychotherapy notes totally segregated and inaccessible to anyone but the therapist, then therapists should be allowed to keep their own personal notes on paper. If such protections are breached, patients will cease to trust the privacy of their revelations and therapy will cease.

Conclusion

Change is part of life, and change in the environment for psychotherapy is inevitable because of advances in the field and in technology and because of the absolute necessity of reining in the cost of health care. I am confident that those of us who offer psychotherapy can ride out the storm and continue to do our work. However, a favorable outcome will require vigilance, energetic advocacy, and impassioned defense of the values of psychotherapy as well as the freedom to live by them.

References