In the ongoing effort to achieve parity for third-party financing of the treatment of mental illness, one of the most tragic failures has been the inability to correct the discriminatory 50% co-payment for outpatient services under Medicare. The resulting eyesore, sitting starkly in the middle of the scene of otherwise receding stigma against patients with mental illness, is a grave injustice and humiliation to our patients and our profession.

How the damage is done

Medicare calculates the discriminatory co-payment in steps. Each year the allowed fee scale is published. Medicare determines whether the charged fee is an allowed fee, then applies to it or the maximum allowed fee, whichever is less, a 37.5% “psychiatric reduction.” The resulting amount, now 62.5% of the allowed fee, is subjected to the standard 20% co-payment that applies to all Part B outpatient services. The net effect is that Medicare pays 50% of the allowed fee instead of 80% as it would for any other medical service. This arrangement applies to all outpatient psychiatric services except CPT 90801, Psychiatric Evaluation, which is paid at 80%. The patient’s diagnosis is the deciding factor: a diagnosis of “mental, psychoneurotic, or personality disorders” invokes the discriminatory process. Apparently the discrimination applies even if a primary care physician uses a general Evaluation and Management code to file a claim with Medicare for treatment of a patient with a diagnosis of mental disorder.

Example: If Mrs. Jones’ allowed Medicare fee for CPT 90807 is $100 (which is substantially lower than prevailing fees for the service), the “psychiatric reduction” brings it to $62.50, 80% of which is Medicare’s payment of $50. Mrs. Jones is then liable for the remaining $50, which the practitioner is obligated to try to collect lest he or she be accused of fraudulently billing $100 while only expecting to be paid a fee of $62.50.

Medigap fills the gap—if the insurance company gets it right

However, if Mrs. Jones has a Medicare supplemental or Medigap insurance policy, that policy is expected to pay Mrs. Jones’ full obligation, including the deductible and co-insurance, which is stated in two parts, regular co-insurance and the psychiatric reduction. Usually that happens at 100% of the patient’s obligation, though some Medigap policies contractually pay only part of the patient’s obligation and expect the patient to pay a small percentage. Because of the complicated process by which psychiatric fees are calculated, Medigap companies have sometimes made errors in the crossover process. Through the intervention of alert psychiatrists and the APA Office of Health Care Systems and Financing, these systems errors have almost invariably been corrected, but practitioners who don’t carefully read their supplemental carriers’ explanations of medical benefits may overlook the fact that their patients’ accounts have been shortchanged.

Secondary coverage by Medicaid rubs salt into the wound

If the patient has Medicaid as a secondary coverage, an insoluble dilemma arises in many states. State Medicaid plans commonly accept only the basic co-insurance (20% of the fee remaining after the psychiatric reduction, amounting to 12.5% of the allowed fee) as their obligation. State Medicaid laws generally require the practitioner to accept this as payment in full of the remaining balance.

Example: Dr. Bones, who is treating Mrs. Jones, files a claim for CPT 90807 and gets a $50 payment from Medicare, followed by a supplemental payment of $12.50 from Medicaid. Medicare requires him to try to collect the remainder of the patient’s obligation, $37.50, from the patient, but Medicaid forbids him to do so. Which rule should he violate? Is it worth it to take on Medicare-Medicaid patients if this dilemma is the result?

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Discrimination by economic status compounds the discrimination by diagnosis

We now see that the Medicare program discriminates most severely against patients with the fewest financial resources. Medicare/Medicaid patients—not only the elderly but also younger people who are disabled, often by mental illness—are in this bind that discourages practitioners from taking responsibility for them. Medicare patients without Medicaid or any private supplemental insurance—who are likely to have the fewest resources in any case because they don’t have access to supplemental insurance through present or past employment, or can’t afford Medigap insurance or qualify for it for health reasons—have to come up with a full 50% of the cost of their outpatient mental health care. This is a powerful disincentive to getting the treatment they need.

Systemic discrimination against psychotherapy

Why is this a relevant matter for a psychotherapy column? Because discriminatory insurance payments for outpatient psychiatric services have long been held hostage to several actuarial shibboleths about insurance coverage for psychotherapy. One of these is so-called moral hazard, the concept that people will use insurance to obtain optional services that they don’t really need, or will actually use it to commit fraud. The classic example is the purchase of fire insurance to cover a failing business, which the policyholder then burns down to collect the insurance money. It is true that many people who need psychotherapy don’t obtain it because of lack of insurance to cover the cost, just as people who need medication don’t obtain or continue it for the same reason. But this is not evidence of fraud or intent to take advantage of the system; rather it is evidence of a tragic failure of the system to provide needed and effective treatment of one class of serious and disabling disease.

Another classic issue in providing insurance, adverse selection, does not apply here, because Medicare is universally available to people who are over 65 or disabled. Medicare is generally their only option, so they wouldn’t be joining it just to use the psychiatric benefit. But tired old misconceptions about psychotherapy do get trotted out when the discrimination is challenged—psychotherapy is optional, endless, unpredictable, ineffective, easily manipulated by the patient to obtain unneeded services, and so on. Extensive evidence, far beyond the scope of this column, is available to refute such claims. A recently published study of the use of psychotherapy for depression in older adults illustrates the factors affecting access to psychotherapy for this very common and serious illness in the elderly. It is now known that the combination of psychotherapy and medication is often more effective than either modality alone for more severe illness, and this is the recommended mode of treatment in some practice guidelines. Anyone who has been in psychotherapy knows that one goes into it because of distress and need for its benefits, not for amusement, self-fulfillment, or coddling. Psychotherapy is hard work, and it takes time because it is a process of repeated experience and learning that realigns associative thought processes and their underlying neural networks. As discoveries mount in the realm of neurobiology and cognitive sciences, the distinction between mental and biological forms of illness becomes ever more meaningless.

Disincentives to outpatient psychiatric treatment are not cost-effective

The Medicare population consists of elderly people and younger people with severe disabilities. Psychiatric illness in this population is often chronic and disabling, and it compounds the morbidity of physical conditions that also afflict the elderly and disabled. If psychiatric disorders go untreated, one can expect higher costs for higher intensity of medical care in hospitals, rehabilitation centers, and nursing homes. In addition, acute and severe psychiatric disorders, such as major depression, new-onset psychotic states, and intense anxiety disorders, also frequently make their first appearance in elderly individuals. Successful treatment in the outpatient setting requires attentive care over a period of months to avoid hospitalization, suicide, delayed recovery from other illnesses, or decline into chronic disability. The double discrimination of Medicare’s “psychiatric reduction” compounds the suffering of such patients whose financial resources are limited, and it also compounds the cost of their medical care.

Advocacy for change

Medicare’s discrimination against people with psychiatric disorders goes back to the beginnings of Medicare in 1965. It is written into law, so that it cannot be changed at the option of the regional carriers that are under contract to administer Medicare. It is ironic that this injustice remains entrenched in Federal law in harsh contrast to Federal government efforts to end dis-
crimination against psychiatric patients in Federal employees’ health benefits and in the Mental Health Parity Act of 1996. A major opportunity for rectification appeared in the Medicare Modernization Act of 2003. Despite active lobbying by the American Psychiatric Association, this wrongful discrimination was not corrected, with opponents citing the expense of paying 30% more of allowed outpatient fees. The actuarially projected cost of rectifying the benefit was considerable. It was estimated at $10 billion over a 10-year period if the discrimination was ended all at once, or nearly $6 billion if phased in over a 6-year period. This assumed a 15% increase in utilization, consistent with the awareness that patients presently may not get needed care because of the high co-payments. However, one must consider that there would be offsetting savings in general medical care and psychiatric hospital and emergency care; that there would be a cost shift from supplemental insurance for those who have it, reducing the amount of new money entering the system; that grave injustice and human suffering are at issue here; and that the failure to right these wrongs occurred in the same legislation that made the Federal government liable for vastly greater outlays for pharmaceuticals. Ironically, the psychotropic medications covered by the new Medicare drug benefit are likely to be used less compliantly, efficiently, and effectively in the lower income Medicare population because of the impeded access to outpatient psychiatric care that is built into Medicare.

Subsequent bills to achieve true parity in Medicare have failed to gain traction, although there are strong supporters in both major parties. Only sustained effort by mental health professionals, their professional organizations, and consumer groups such as NAMI and AARP in all parts of the country will turn the tide. Mental disorders are equal-opportunity predators on a large part of our population, regardless of party affiliation. Untreated, they significantly raise the cost of all forms of health care. Effective outpatient care that offers psychotherapy and pharmacotherapy, separately or combined, prevents costly deterioration, relapses, and suicide, as well as enhancing compliance with good medical care in general. Both humanitarian and economic forces dictate that it is time to remove this relic of the Middle Ages from our Medicare law.

References
3. Personal communication, APA Division of Government Relations.