Weekly Checkup

Getting Ghosted

JACKSON HAMMOND | JUNE 3, 2022

May was Mental Health Month, and in a nation where "deaths of despair" (those deaths due to suicide, drug use, or alcoholism) have jumped alarmingly in the last few years, there cannot be enough discussion about mental health. In that spirit, this week we'll look at one of the major challenges to receiving adequate mental health care in the United States: ghost networks.

A ghost network is a term that describes inaccurate provider lists maintained by insurers, where the provider list shows many more accessible providers than the network actually has. For example, researchers in a 2015 study called 360 providers in the Blue Cross Blue Shield (BCBS) network for three major cities and found that after two rounds of calling, appointments could only be made with 26 percent of providers. **A similar study in 2017 looking at access to pediatric care providers found that bookings could be made with only 17 percent of the child psychiatrists (compared to 40 percent of the pediatricians) in the BCBS network for the cities studied**.

How substantial is this problem? A trio of lawsuits filed last year by the San Diego City Attorney against three major networks (Kaiser, Molina, and Health Net) allege significant provider network list inaccuracy rates for psychiatric and mental health providers: 30 percent for Kaiser, 35 percent for Health Net, and over 80 percent for Molina. If true, those rates are shocking, but the suits are still pending and these insurers disputed those figures.

The inaccuracies that create these ghost networks come with a cost to those seeking treatment. As two of depression's most notorious effects are apathy and hopelessness, those experiencing a deep crisis find it difficult to make one phone call to help themselves — let alone a dozen or more. And the more often a depressed patient hears "no," the less likely they may be to continue their search for help. A mental health emergency is often a race against the clock, and lives may be lost when help isn't found.

How do these inaccuracies happen in the first place? Depending on who you ask, it involves some mixture of bureaucratic bungling, insurer impropriety, provider greed, and good old-fashioned human error. **State laws requiring providers to maintain updated networks have not been consistently enforced and penalties are sparse. Insurers lack incentives to make it easier for patients to access pricey care**. Providers themselves often prefer cash clients even if the provider is part of a network. They often see insured patients as a "Plan B," taking cash clients before insured ones because cash clients pay substantially more. Finally, insurers say it's difficult to keep updated provider lists when providers change contact information often and leave networks without notice.

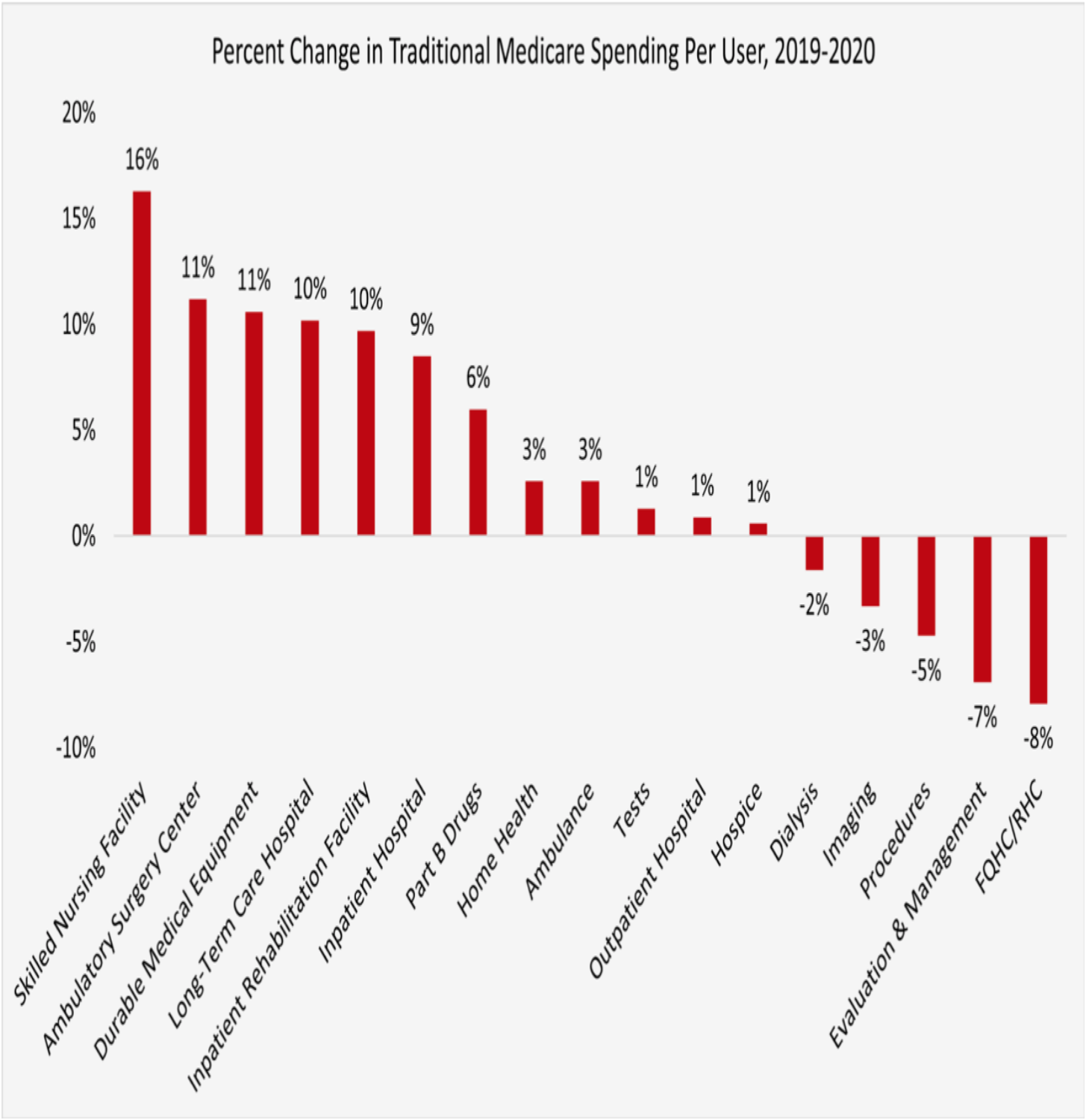
But ghost networks don't exist purely due to misaligned incentives or errors. They are also the result of a major supply crisis in mental health providers. Only 28.1 percent of the mental health care need in the United States is being met, in large part due to a general shortage of mental health providers. Another major issue is that just 42.7 percent of psychiatrists and 19.3 percent of nonphysician mental health care providers (e.g. therapists) participate in mental health insurance networks. Part of this is structural: Insurers were not required until recently to treat mental health services as on par with physical health services, so mental health coverage was historically scarce. As my colleague Margaret Barnhorst discussed in a previous Weekly Checkup , insurers are now required by the Mental Health Parity and Addiction Equity Act of 2008 to cover "illnesses of

the brain no more restrictively than illnesses of the body." As Barnhorst points out, coverage parity is difficult to define and was even more difficult to enforce before 2021 statutory requirements to document parity compliance. But parity issues are only part of the reason insurance reimbursements for mental health services are often much less than cash payments. **As noted, most physicians would (and do) charge cash patients significantly more than they charge insurance plans – after all, that's why people have insurance in the first place – so one might find it hard to believe that this in-network shortage is entirely the fault of insurers for not paying enough**. There simply aren't enough mental health providers to meet demand, and as a result, providers can often charge high fees for their services. **Reforms to ensure accurate networks may be helpful, but the most effective solution to our nation's mental health crisis has more to do with basic economics: When demand is high, increase the supply**.

CHART REVIEW: TRADITIONAL MEDICARE SPENDING PER USER, 2019-2020

Margaret Barnhorst, Health Care Policy Fellow

According to a new analysis from the Kaiser Family Foundation, based on data from the Centers for Medicare and Medicaid Services, traditional fee-for-service Medicare spending per user increased across the majority of services from 2019 to 2020. As shown in the chart below, users of skilled nursing facilities faced the largest percent increase in spending per user, which climbed roughly 16 percent from $16,700 in 2019 to $19,400 in 2020. This jump in spending, along with large percent increases in the spending per user on other inpatient services and long-term care facilities, suggests that beneficiaries required more intensive and costly care at these facilities in 2020 relative to 2019. In contrast, spending per user for traditional Medicare users of dialysis, imaging, procedures, evaluation and management, and federally qualified health centers or rural health centers (FQHC/RHC) decreased from 2019 to 2020. While most of these decreases were driven by lower service use and delayed elective procedures as a result of pandemic-related closures, dialysis saw an increase in the number of users in 2020 but a decrease in total spending, meaning that the overall percent decrease in spending per user on dialysis was the result of lower-cost options.


Percent Change in Traditional Medicare Spending Per User, 2019-2020
20%
15%
10%
5%
0%
-5%
-10%
16%
11%
11%
10%
10%
9%
6%
3%
3%
1%
1%
1%
-2%
-3%
-5%
-7%
-8%
Skilled Nursing Facility
Ambulatory Surgery Center
Durable Medical Equipment
Long-Term Care Hospital
Inpatient Rehabilitation Facility
Inpatient Hospital
Part B Drugs
Home Health
Ambulance
Tests
Outpatient Hospital
Hospice
Dialysis
Imaging
Procedures
Evaluation & Management
FQHC/RHC