A Primer on Mental Healthcare Supply and Demand

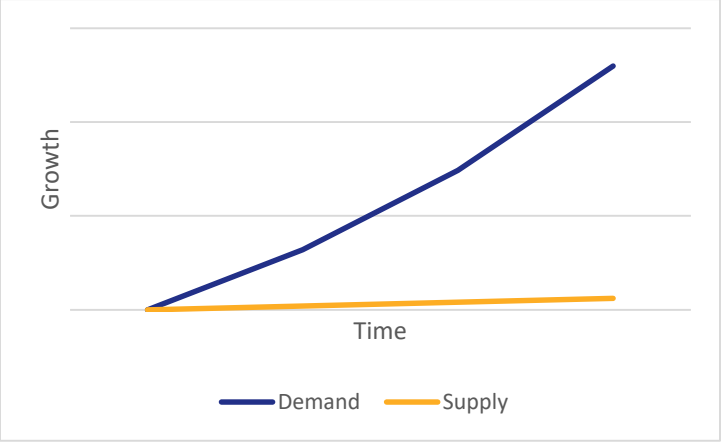
Most of us have been part of at least one 'we have a serious mental healthcare issue in America' conversation within the past several years. There are assuredly many aspects of this issue in our country. One aspect, and the focus of this paper, is an apparent mental health provider shortage (also referred to as behavioral health providers or psychotherapists[1]). Additionally, this paper will explore some potential steps forward in addressing this concern.

Mental Health Provider Supply vs. Demand

A 2016 study done by the U.S. Department of Health and Human Services (DHHS) projected a shortage of mental health providers of up to 25% by 2025[i]. In other words, demand for mental health providers will significantly exceed supply. That study certainly did not include a projected scenario of the COVID-19 global pandemic, which has only exacerbated demand for mental health care and its providers. A tracking poll from Kaiser Family Foundation (KFF) found that in mid-July 2020, 53% of adults in the U.S. reported that their mental health has been negatively impacted by the COVID-19 pandemic, including difficulty sleeping or eating, increased alcohol or substance use, worsening chronic conditions, etc[ii].

The DHHS study defined demand as the population reported as having a behavioral health disorder. In reality, demand also includes the population observing mental health symptoms that are not severe enough to qualify as a behavioral health disorder. In other words, individuals seeking mental health treatment in a preventive manner, prior to untreated symptoms becoming severe enough to diagnose a disorder. Recall that health is not simply defined as the absence of disease or illness, but 'a state of complete physical, mental, and social well-being'.

According to a data report released by the Health Care Cost Institute (HCCI), utilization of psychiatric services increased 32% from 2014-2018[iii]. There is no doubt that we have seen and will likely continue to see such high trends in demand for mental healthcare. What about supply? Is the supply trending at an accommodating rate? The short answer is no. The DHHS study used a microsimulation model to project forward supply as influenced by multiple variable factors such as population growth, aging, economic conditions, insurance coverage, training, retirements, mortality, etc. This model projected a 6% increase in supply from the base year (2013) to the projection year (2025), which is a 12-year period. To compare to the 4-year period quoted for the 32% trend in demand, that is equivalent to a 2% trend in supply over 4 years.



[1] The terms 'mental health providers', 'behavioral health providers', and 'psychotherapists' are all used as cohesive terms for multiple professions including psychiatrists, psychologists, counseling, etc.

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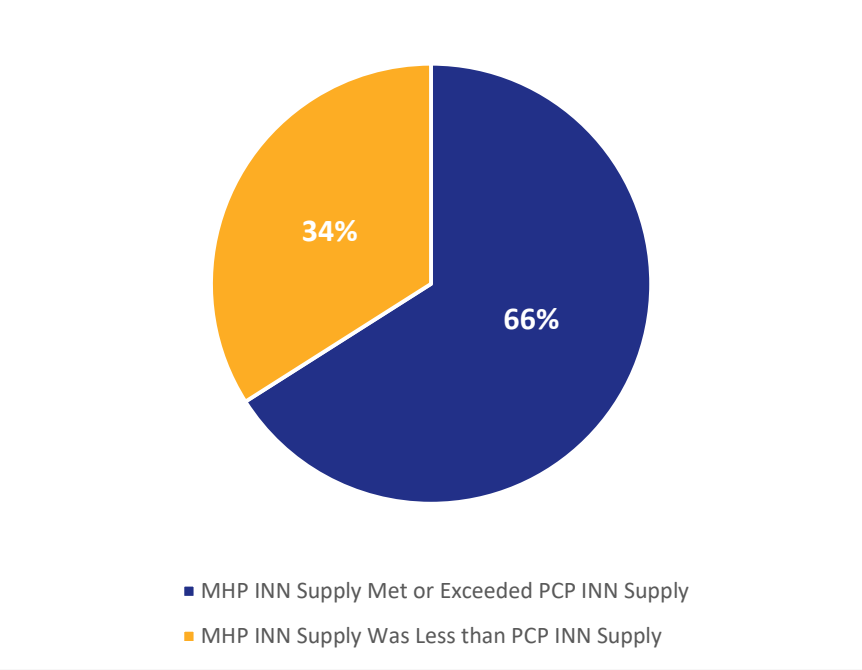
Digging deeper into the supply side of mental healthcare, aside from the low trend, there are major accessibility barriers. These barriers only further decrease the 'realizable' supply which is already inadequate for demand. One of these barriers is acceptance of insurance.

To compare the supply of mental health care providers to the supply of primary care providers as a benchmark, data was collected from the CMS National Provider Identification (NPI) database at a county level[iv]. When simply comparing the two types of providers, 82% of counties had an equal amount or more mental health care providers compared to primary care providers per capita. This was the case for 88% of urban counties and 78% for rural counties. However, study results have shown that approximately 90% of primary care providers accept insurance while only approximately 55% of mental health care providers accept insurance[v].

When the county-level NPI data was adjusted for the difference in in-network (INN) coverage, only 66% of counties had an equal amount or more 'in-network' mental health care providers (MHP) compared to 'in-network' primary care providers (PCP) per capita. This was the case for 75% of urban counties, but only 60% of rural counties.



Unfortunately, there is not any reasonably accessible data to further adjust for providers actively practicing and accepting new patients, which would likely further reduce the met comparability of the two types of providers. In a survey published in June 2020 by Health Affairs, 53% of participants reported an inaccuracy in their insurer's mental health provider directory[vi]. Inaccuracies included incorrect contact information for the provider, the provider not actually being in-network, and/or the provider not actually taking new patients. A separate study conducted in 2018 found that out of 100 mental health providers sampled from an insurance provider directory in the mid-Atlantic region, only 19 could be reached, were accepting new patients, were in-network, and could provide an appointment within three weeks[vii]. These study results beg the question: how many of the providers counted as 'supply' are really available to provide care?

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Potential Steps Forward

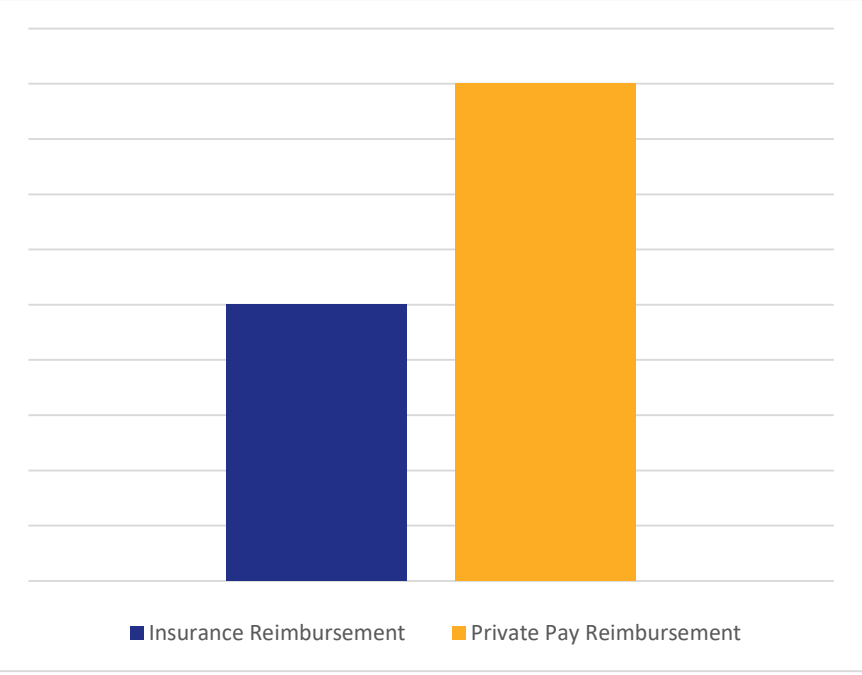
Recruitment

An obvious option for increasing the supply of mental health providers is recruitment. Even if all mental health providers accepted insurance, a shortage still remains and supply trend is still below demand, so recruitment is essential. Many strategies have been discussed regarding recruitment and retention including but not limited to: (1) increased scholarship allotments for behavioral health, (2) governmental incentives, subsidy programs, and loan forgiveness for behavioral health practices, (3) higher-quality education, training, and mentorship programs, and (4) increased salaries (including benefits). It is up to educational institutions, elected officials' legislative action, and employers, to see that these strategies are used or even optimized.

Reimbursement

Most mental health providers compensation, either through their employer or their own stand-alone practice, is majorly or even solely dependent upon either the rate billed to private-pay patients or the level of reimbursement they receive through their patients' insurance.

Psychotherapists receive 80% more in reimbursement per unit on average for private-pay patients than for patients through insurance[2]. A study published in 2017 found that in-network primary care and other specialist-type providers are reimbursed through insurance 20% more on average than in-network behavioral care providers[viii]. Due to the short supply and high demand for mental health providers, many choose to not accept insurance and only accept patients through private pay. Furthermore, some practices accept insurance but can only allow a certain portion of their patient slots to be insurance-paying patients because they cannot afford overhead without some higher reimbursement from private-paying patients. This restricts accessible supply for many that cannot afford psychotherapy without the financial support of insurance.



[2] Based on sample FairHealth Consumer data.

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Network Standards

The Mental Health Parity and Addiction Equity Act (MHPAEA) is mostly known for its requirement that cost sharing levels to the covered member may not be any greater for mental health services than for comparable physical health services. MHPAEA also mandates that a health plan may not impose nonquantitative treatment limitations (NQTLs) more stringently than applied to medical benefits in the same classification. NQTLs include processes and standards for accepting a provider as an in-network provider. However, this does not require an equal number of providers, equal provider reimbursement levels, nor any solid benchmark for network adequacy compared to equivalent physical care. The MHPAEA does vaguely mention that network adequacy, "while not specifically enumerated in the illustrative list of NQTLs, must be applied in a manner that complies with final regulations".

A study conducted in 2016 and published by Health Affairs found that, on average, plan networks included 24% of all primary care providers and 11% of all mental health care providers in a given state-level market[ix]. Given the data, the parity is clearly interpreted to mean that a health plan is not required to ensure equal availability and in-network access to mental health providers, but rather they cannot deny in-network applications or have an application process more stringent for mental health providers as other providers. If it is not interpreted this way, then there must be a lack of compliance and/or enforcement across the country. Stricter parity laws and/or compliance when it comes to network standards has great potential to increase accessible mental health provider supply. On the same token, it would give providers more negotiating power when it comes to achieving levels of reimbursement more comparable to physical care services.

Telehealth

Telehealth, specifically telepsychiatry, can also improve accessibility to supply. Utilization of telehealth has been on the rise for some time, and the COVID-19 pandemic generated an exponential spike in telehealth usage. According to FairHealth's Monthly Telehealth Regional Tracker in November 2020, telehealth utilization increased 4-8 times the utilization just one year prior[x]. Psychotherapy now taking 2 of the top 5 procedure codes in all of the 4 regions, where it took 0 of the top 5 procedure codes in half of the regions in the prior year.

Telepsychiatry has the capacity to increase privacy and decrease perceived stigma encouraging individuals to pursue care and increase practical access for patients especially in rural areas where it may otherwise require a 60+ minute commute each way otherwise. However, in a recent study conducted by the COVID-19 Healthcare Coalition, 60-70% of providers anticipate technological access and/or literacy to be a barrier to telehealth access[xi]. According to Census data, in 2016, 18% of households were without internet access, with the largest disparities for household incomes less than $25,000 (41% without access), limited English-speaking households (37% without access), householders age 65+ (32% without access), African American households (27% without access), and rural households (26% without access)[xii]. So, while telehealth is a promising method for expanding access to mental healthcare, there is still much to be done in the way of access inequities.

Preventive Mental Healthcare

There is not much to be done about the rising demand for mental healthcare. In fact, rising awareness and efforts towards thriving mental health are a good thing, and the goal should not be to suppress this trend. But there is potential to shift utilization towards preventive care and reduce the severity and cost of care. In the same way that early screening for cancer and early intervention can increase success in remission and reduce cost and severity of necessary care, just as access to telehealth and other primary care can reduce ER utilization, and how annual physicals are essential, preventive mental healthcare can offer the capability to reduce hospitalizations and need for medication. Data published by the CDC found that 28% of mental health expenditures are inpatient and 27% are for prescriptions drug, and inpatient mental healthcare can cost 3 or more times the cost of outpatient care[xiii].

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Several employers allow the benefit of a certain number of therapy sessions per year, with all expenses covered[xiv]. Health plans also have the opportunity to fully cover a certain number of initial mental health outpatient visits per year, though it is not currently common. There was some exception in 2020 where many insurers waived or reduced cost sharing for telepsychiatry in response to COVID-19 and decreased utilization of other care. Incentivizing and steering individuals towards lower cost options for mental healthcare presents the capability to scale down the cost of demand for mental healthcare.

It Takes Action

There is no doubt that mental health has fallen way behind as a priority in our society compared with physical health. We are starting to realize that lower priority on mental health has less than ideal, and in many cases deadly consequences. As priorities continue shifting to a complete state of health, across physical, mental, and social well-being, demand for mental health will continue to increase accordingly. But past and present data, as well as future projections, prove that accessible supply is not increasing at the same rate and is falling further and further behind. However, there are many opportunities to help close the gap between supply and demand, all it takes is focus and action from educational institutions, elected officials, insurance regulators, employers, mental health providers, and insurance companies.

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- **Healthcare**
- **Insurance**
- **Financial Risk**
- **Data Analysis**

[i] National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025. U.S. Department of Health and Human Services, 2016, bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf.

[ii] Panchal, Nirmita, et al. The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation, Aug. 2020, www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

[iii] "2018 HEALTH CARE COST AND UTILIZATION REPORT." Health Care Cost Institute, Feb. 2020, healthcostinstitute.org/images/pdfs/HCCI_2018_Health_Care_Cost_and_Utilization_Report.pdf.

[iv] "Mental Health Providers." County Health Rankings & Roadmaps, www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/clinical-care/access-to-care/mental-health-providers.

[v] Bishop, Tara F, et al. "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care." JAMA Psychiatry, U.S. National Library of Medicine, Feb. 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/.

[vi] Susan, Busch, and Kyanko Kelly. Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills: Health Affairs Journal. Health Affairs, June 2020, www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

[vii] Motovidlak, Dawn. Why so Many People Have Untreated Mental Health Conditions. Society of Actuaries, June 2018, www.soa.org/globalassets/assets/library/newsletters/health-watch-newsletter/2018/june/hsn-2018-iss86-motovidlak.pdf.

[viii] Melek, Stephen, et al. Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates. Milliman, Dec. 2017, www.equitasproject.org/wp-content/uploads/2017/09/NQTLDisparityAnalysis.pdf.

[ix] Zhu, Jane M., et al. Networks In ACA Marketplaces Are Narrower For Mental Health Care Than For Primary Care: Health Affairs Journal. Health Affairs, Sept. 2017, www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0325.

[x] Monthly Telehealth Regional Tracker: FAIR Health. 2020, www.fairhealth.org/states-by-the-numbers/telehealth.

[xi] TELEHEALTH IMPACT: PHYSICIAN SURVEY ANALYSIS. COVID-19 Healthcare Coalition, 2020, c19hcc.org/telehealth/physician-survey-analysis/.

[xii] "Computer and Internet Use in the United States: 2016." American Community Survey Reports, United States Census Bureau, 2016, www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-39.pdf.

[xiii] Health, United States, 2016. Centers for Disease Control and Prevention, 2016, www.cdc.gov/nchs/data/hus/hus16.pdf.

[xiv] Ward, Marguerite. 12 Companies Boosting Benefits so Employees Don't Feel Isolated or Lonely during the Coronavirus Crisis. Business Insider, Sept. 2020, www.businessinsider.com/companies-offering-more-mental-health-benefits-amid-coronavirus-2020-4.

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