Implementation of Mental Health Parity: How Good is it from Psychologists' Points of View?

Results of Division 42 Parity Survey

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Division 42 Advocacy Committee

In October 2011, the Division 42 Advocacy Committee surveyed psychologists about their experiences with the implementation of mental health parity via announcements to email listservs, Twitter, and LinkedIn, to Division 42 members, state, provincial and territorial psychological association (SPTA) Presidents and numerous SPTA listservs, Council of Executives of SPTAs, Division 31 Listserv, Division Presidents Listserv, STATEPSYCH Listserv, and the Council of Representatives Listserv. The hyperlink to the online survey was widely disseminated, and was available for response for approximately 45 days.

Sample Characteristics

Total Respondents	1005
Licensed to provide services	961 (95.6%)
Degree with which licensed to provide services	887 responding
Doctoral (PhD, PsyD, EdD, similar)	877 (98.9% of those responding)
Master's	6 (0.7% of those responding)
Other	4 (0.5% of those responding)
Primary practice settings (select one or more)	870 responding
Solo private practice	626 (72% of those responding)
Group independent practice	192 (22.1% of those responding)
Publicly funded facility	31 (3.6% of those responding)
Integrated care system	17 (2% of those responding)
University Health Clinic/Hospital	14 (1.6%)
Other (HMO, University Mental Health Clinic, Psychology Department Mental Health Clinic, Other)	59 (6.8% of those responding)
Accept reimbursement from public and/or private health insurance plans	883 responding
Yes	754 (85.4% of those responding)
No	129 (14.6% of those responding)

The committee decided to report any activities for which 15% or more of respondents reported a change (increase or decrease) in the frequency the activities surveyed, and for activities which had 60 or more responses.

Respondents also provided their locations of practice by city, state and zip code. This will allow for further analysis of trends in experiences with different payers' activities by geographic region, and will be provided in a future report.

Results

After examining demographics, the first key question focused on public health insurance plans, asking "For each plan with which you have had sufficient experience since 1/1/2011, please rate whether you have observed an

increase, decrease, or no apparent change in the frequency of the indicated activity. Please rate whether the ACTIVITY FREQUENCY has changed or not, for example, whether more or fewer sessions are being authorized. If you do not perform particular services or work with particular plans, please leave those unrated."

A total of 427 answered this question, representing 44.4% of the total 961 licensed psychologists responding.

Activities asked to be rated (in this and subsequent items) were

- Preauthorization for initial evaluation or
- Preauthorization for treatment visits
- Re-authorization for treatment visits
- Approval for Severe Mental Illness conditions only
- Intensive telephone reviews
- Company dropping mental health benefits
- Utilization Review (UR) for psychological testing
- UR for neuropsychological testing
- UR for intensive outpatient treatment, i.e. 2 or more sessions/week
- UR for inpatient treatment
- UR for EAP products/services
- UR for substance abuse/dependence treatment (in- or outpatient)
- UR for Intensive Outpatient Treatment (IOP) program, e.g., "Day Treatment," integrated service and support program
- Allowing more treatment visits prior to reauthorization
- Allowing fewer treatment visits prior to reauthorization
- Co-pays or deductibles which stipulate psychologists as specialists

Plans asked to be rated for change in activities

Public Health Insurance Plans	Private Health Insurance Plans
Medicare Part B	Aetna
SCHIP	Blue Cross Blue Shield
Medicaid	CIGNA
Medicaid Managed Care	Humana
VA Healthcare	Kaiser Permanente
Tricare, CHAMPUS, CHAMPVA	United Health Care (UHC)
	WellPoint

Results for Public Health Plans

For **Medicare Part B**, respondents reported little or no change in the manner in which these benefits have been administered on almost all the items. Of note, of 223 reporting about co-pays or deductibles which stipulate psychologists as specialists, 33 (14.8%) experienced an increase in the frequency with which psychologists were identified as specialists, while 13 (5.8%) reported a decrease, and 177 () reported no change. This suggests that in the area of identifying psychologists as specialists, Medicare carriers may not be fully compliant with the requirements of parity legislation.

A total of 111 respondents reported regarding utilization review (UR) for neuropsychological testing. Of those reporting, 12 (10.8%) reported an increase in UR activities, and 98 (88.3%) reported no change in the level of UR. Some psychologists do report experience increased UR by Medicare carriers in relation to neuropsychological testing.

Medicaid: A total of 105 respondents reported about preauthorization for initial evaluations for patients with Medicaid. Fifteen (14.3%) said that they had seen an increase in requirements for preauthorization, and 82 (78.1%) had seen no change. Fifteen of 95 reported experiencing increased requests for preauthorization for treatment visits, 5 reported a decrease, and 75 reported no change. Fourteen of 85 reported experi-

encing an increase in the need for re-authorization of treatment visits, 2 reported a decrease in frequency of requests for re-authorization, and 69 reported no change. Ten of 61 (16%) reported experiencing an increasing frequency of dropped Medicaid mental health benefits, 51 reported no change, and none reported a decreased frequency of dropped Medicaid mental health benefits. Such reports could reflect the contraction of benefits for Medicaid beneficiaries in various states given the state budget parameters. Increase UR was reported for psychological and neuropsychological testing, and for approval for inpatient and intensive outpatient treatment, however, but the number of respondents for these activities was below our threshold for further analysis.

Medicaid Managed Care: On almost all the items, respondents reported an increase in activities related to oversight of care. Twenty-four of 90 responding (27%) reported an increased need to pre-authorize an initial evaluation, while 10 (11.1%) reported a decrease in this activity. Twenty-four of eighty respondents (30%) reported an increase in a requirement of pre-authorization for treatment, with 12 (15%) reporting a decrease in this requirement. Of seventy respondents reporting the requirement for re-authorization for treatment visits, 19 (27%) reported an increase in this requirement, while 11 (16%) reported a decrease. Of 42 respondents reporting about psychological testing, 16 (38%) reported an increase in UR activities, while 2 (4.8%) reported a decrease. Regarding plans allowing fewer visits prior to re-authorization, of 49 respondents reporting, 16 (33%) experienced increased frequency of fewer visits allowed, while 7 (14%) reported experiencing a decrease.

An especially worrisome trend emerges in relation to a possible decrease in access to mental health benefits for the vulnerable population covered by Medicaid Managed Care. Fifty three respondents (5.27% of total sample) answered the query regarding a company dropping mental health benefits. Of those, 13 (24.5%) reported an increase in companies dropping mental health benefits, while 39 (73.6%) reported no change

Tricare, CHAMPUS, and CHAMPVA: Eight of 41 reporting (19.5%) experienced increased frequency of UR for neuropsychological testing, and 4 of 26 (15.4%) reported increased frequency of UR for inpatient treatment. Otherwise, the majority of those reporting experienced no changes in the frequency of authorization or review activities for these insurers. The numbers reporting regarding increased UR frequency for neuropsychological testing and inpatient treatment are relatively small, but do suggest possible changes potentially worth further exploration.

Results for Private Health Plans

A more detailed analysis will be provided in a subsequent report. Briefly, 345 respondents provided information about Blue Cross Blue Shield, 230 reported about United Health, 217 reported on Aetna, 140 provided reports about Cigna, 84 reported regarding Humana, 23 regarding WellPoint, and 11 regarding Kaiser Permanente. Based on respondents ratings, results suggest psychologists are experiencing increased requirements for pre-authorization for initial evaluations and treatment visits, increasing frequency of UR for additional treatment visits, as well as a tendency to allow fewer treatment visits prior to the need for re-authorization. At least half of the companies are now requiring intensive telephone reviews. Respondents also reported co-payments to be at the same level as specialists with increased frequency. Utilization review for psychological testing and neuropsychological testing appears to be increasing, although too few responses were provided for some of the companies surveyed.

In addition to asking respondents to report their experiences with identified public and private payers, reports for any additional insurance plans with which they had sufficient experience was requested. A total of 107 respondents answered this item, with as many as 99 reporting experience with at least one additional insurer. Individual companies rated include Optum Health, GHI, MHN, Oxford, Value Options, PacifiCare and many others. Of the sixteen possible activities, no reported changes were observed for thirteen since the implementation of parity. Sixty-three percent (N = 17) of 27 respondents rating utilization review (UR) for intensive outpatient treatment (2 or more sessions/week) reported observing increased UR since parity implementation. Thirty-two of 68 raters (47%) reported having increasingly experienced fewer treatment visits being allowed prior to reauthorization. And 38 of 99 raters (38.4%) reported increased frequency of reauthorization required for treatment visits in a first company rated.

Preliminary results from companies additionally reported by respondents do suggest most psychologists are not observing substantial changes in many of the authorization and review activities typically encountered in dealing with third party payers. There is evidence suggesting increased UR may be occurring in cases requiring two or more treatment visits per week, possible reduction in the number of treatment visits allowed prior to re-authorization, as well as an increasing frequency in re-authorization requirements. Such changes would fall under the "nonquantitative" aspects of parity, though certainly could affect access to mental health services, the overall value of mental health benefits, and the burden on and cost to the practicing psychologist. If such changes are occurring in the mental health arena, one key question is whether similar changes are also occurring in medical benefits, or whether these might differentially impact mental

health services. If the effect is primarily in mental health, preventing such disparity was, of course, the core purpose of parity legislation.

We additionally asked, "For the health insurance plans and services shown, indicate whether your reimbursement in 2011 has increased, stayed the same or decreased relative to 2010. Assume services are provided in the outpatient setting. If you rate "other" companies than those listed, you will have the opportunity to identify those companies in the following question. These need not be the same companies previously rated."

	Same	Decreased	Percent of Respondents Answering Item
Initial Visit			
Medicare Part B	31%	60%	26.8%
Aetna	75.9%		19%
BCBS	45.8%	40.7%	29.5%
Cigna	69.1%		13.5%
UHC	69.4%		20.4%
Other	67.4%		9.4%
Individual Psychotherapy			
Medicare Part B	29.8%	68.7%	27.8%
Aetna	73.3%		19%
BCBS	45.1%	43.8%	30%
Cigna	65%		13.6%
UHC	65.5%	32%	20.4%
Other	64.9%		9.3%
Family Psychotherapy			
Medicare	65%	11.9%	
Aetna	72%		11.7%
BCBS	43.3%	46.5%	18.6%
Cigna	73.5%		8.2%
United Health	70.7%		12.2%

These data suggest that since parity implementation, reimbursement for initial sessions, individual and family psychotherapy have remained the same for Aetna, and Cigna. Decreases are reported for Medicare Part B and Blue Cross Blue Shield on all three procedures, and for individual psychotherapy and possibly in initial visits for UBH. in individual psychotherapy and possibly in initial session reimbursement.

We additionally asked about any successes or improvements respondents experienced since implementation of Parity. A sampling of those comments is below:

- Less hassle about session limits and approval for psych testing, esp. thru Tricare.
- Some patients were allowed more sessions weekly and annually without the need for prior approval.
- Documentation is less restrictive. i.e., what is required to get authorizations approved is not as complex; paper work is more streamlined.
- With the exception of individual plans, which still don't have to implement parity (which I think is absurd and should never have been allowed as a loophole), in Oregon it's going pretty well. We are hearing that the costs of parity have not turned out to be as high as the insurance company predicted.
- One local hospital system's health insurance re-categorized mental health services from "specialist" with a $40 copay to "office visit" with a $20 copay. Yay!! They even reprocessed all claims retroactively to 1/2011. Unfortunately, next year they are going with an 80/20 copay structure instead of a flat fee, so it will cost patients more.
- More sessions are approved without the need to submit an Outpatient Treatment Review form or in some cases no authorization is needed for continued services after the initial authorization is granted.
- Overall, confusion - some companies have stopped reviews while others are increased intrusions. Also questions about co-payment are unclear if there is one for medical and one for psychological or just one.
- I have tried to invoke "parity" in reviews with UHC and was told they would deny the request due to "insufficiency of information."

We additionally surveyed psychologists regarding other problematic practices by insurers previously reported. These include contacts from payers to attempt to "renegotiate" payments in return for "expedited" payment; payers basing "usual and customary" payments dubious or unknown data; and recovery of monies previously reimbursed ("clawbacks"). Details of psychologists experiences with these activities will also be provided

in a future report. Briefly at this time, suffice it to say these practices may be more common than previously known.

Conclusions

The Advocacy Committee explored what conclusions could be gleaned from this survey. First, there was concern that the public insurance entities were dropping people from their rolls, thereby affecting the most vulnerable populations who had no access to other mental health benefits. In addition, Medicare Part B is implementing reimbursement parity over 5 years which will be completed in 2014. Caution is urged when assuming that non-quantitative parity will also be implemented. Currently instead of the 80/20% benefit for physical health, it is now 60/40%. There is, however, information from the Congressional Budget office that Congress could change the eligibility age from 65 to 67 years of age to save money and have seniors shoulder more of the costs. This certainly begs the question of whose money this saves. The hope is that military insurance for dependents and retired will implement full parity.

It appears that there is still a great deal of confusion about whether or not psychologists qualify at the same level as do primary care providers. By law they do; however, insurance companies are at times disputing such.

There was a lot of anger and frustration expressed with insurance reimbursement rates, especially Medicare. Such goes beyond parity. Because each insurance company and each employer contract has different requirements for authorization, number of sessions, payment, deductibles, co-pays, methods of submitting claims and paying claims it becomes necessary to hire a specialist to do the insurance billing. Some respondents expressed disappointment that there was not more improvement with the parity law.

One challenge with this type of survey is there are so many different private insurance plans. In addition, some are non-profit and others with very similar names are for profit. This changes from state to state as well. Some states have partial parity for only certain serious mental health conditions. This would apply to the individual plans in that state and those for state employees. California is such an example. In addition, Medicaid plans differ based on state regulations written by legislators. Given revenue shortfalls, the most vulnerable usually are affected first. Such leaves Americans with a patchwork quilt of policies for patients and their psychologists to try to understand.

In a recent issue of Progress Notes, an online newsletter for California Psychological Association members (**http://www.cpapsych.org/associations/13260/files/files/publications/progressnotes/2011/Vol.%2011,No.1.pdf**) , Dr. Chuck Faltz noted, "ACA (Affordable Care Act) expressly identifies mental health and addictions treatment services are as essential benefits, along with rehabilitative and 'habilitative' services. However, the extent to which specific behavioral health services are covered will depend in large part on which existing insurance plan each state selects as its "benchmark" plan – that is, the plan on which the EHB (Essential Health Benefits) package in that state will be based. If the state selects a plan with slim coverage of behavioral health services or a strict interpretation of what is considered 'rehabilitative' services, it could affect individuals' ability to access these services."

In addition, Dr. Faltz wrote, "The HHS guidance confirms that the 2008 Mental Health Parity and Addictions Equity Act applies to individual plans as well as small group plans – a provision that was inserted into the law as an amendment by Senator Debbie Stabenow (D-MI) during the health reform debate. If the plan that a state selects as the benchmark plan does not currently comply with the parity law, modifications must be made to the benefits package to bring it into compliance with parity."

Recommendations for Future Consideration

1. It is recommended that further investigation of the practices of Blue Cross Blue Shield and UHC be conducted. A further survey focusing on these insurers' records with reimbursement would be a start. If the data are compelling, a referral to APAPO for possible legal action and/or meetings with BCBS and UHC officials may be indicated.
2. Reporting insurance companies which appear not to be following Parity to APAPO and/or appropriate regulatory and enforcement agencies may also be useful.
3. Psychologists may benefit from additional training particularly regarding the requirements of the Parity law, to assist in identifying potentially non-compliant practices, may help with implementation in day-to-day practice.