Parity From the Consumer Perspective: Implications for Federal Implementation From New York's Parity Evaluation

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This column reports results from a qualitative study of employees' knowledge of and access to mental health benefits after implementation of New York State's parity law in 2007. Fifty-four employed individuals with insurance coverage were interviewed by telephone (32 adults with mental illness and 22 parents of children with mental illness). Contrary to findings of previous studies, most had been informed of their coverage limits before the parity law but were unaware of their extended parity benefits. They cited their lack of knowledge and inadequate communication from their health plan as barriers to accessing benefits. They also reported barriers to accessing high-quality services. The findings indicate an urgent need for benefits education and monitoring of health plan communications on a federal level. (*Psychiatric Services* 62: 344–346, 2011)

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The Mental Health Parity Act of 1996 prohibited health plans from imposing annual or lifetime dollar limits on mental health benefits that were less favorable than limits imposed on medical-surgical benefits. However, the law did not prohibit health insurance plans from imposing disparate treatment limitations on the number of mental health visits and hospital days covered, nor did the law mandate equality in cost-sharing requirements. The federal Mental Health Parity and Addiction Equity Act of 2008, which went into effect on January 1, 2010, prohibits such disparities in coverage. The law covers self- and fully insured health plans with more than 50 employees and mandates equality in treatment limitations for mental health and medical-surgical benefits, as well as in the cost-sharing requirements and managed care practices used to regulate the benefits.

At the state level, 49 states have passed mental health parity laws that vary on three dimensions: the size of companies and range of diagnoses covered by the law and the mandated level of mental health coverage stipulated in the law. New York State's parity law, Timothy's Law, became effective in January 2007. It mandates all fully insured companies that issue health insurance regardless of size in New York State to cover a base benefit of 20 outpatient mental health visits and 30 inpatient hospital days for all members and requires parity between cost-sharing requirements for mental health and medical-surgical coverage. In addition, for companies with more than 50 employees, it extends full mental health parity coverage (referred to as "full parity" in this column) for a number of biologically based diagnoses and childhood emotional disorders by mandating equality between the treatment limitations imposed on coverage of these conditions and medical-surgical coverage.

Previous evaluations of mental health parity laws have found that employer costs do not significantly increase after parity implementation. In addition, these studies have concluded that although parity laws decrease out-of-pocket spending for mental health services, they have minimal or no impact on overall benefit utilization or perceived benefit quality and access (1–6). One reason that has been identified for the lack of significant increases in spending and benefit utilization is greater use of managed care strategies for mental health benefits after parity implementation (2,6,7). At the same time, it is plausible that the reduction in out-of-pocket spending is limited to individuals who are aware of their extended benefits and that a prevailing lack of knowledge about benefits may contribute to the minimal impact on overall benefit utilization and perceived benefit quality and access.

Awareness of health services has been found to have a strong influence on service utilization (8). Yet few investigations have directly examined consumers' awareness of and access to enhanced mental health benefits after parity implementation. Only two parity evaluations have included mental health consumers (7,9). The investigators found that the majority of participants were unfamiliar with the law

and expressed a need for education about parity. Participants cited the narrow definition of "medical necessity" and the exemption of managed care practices from parity requirements as barriers to improved access to mental health care.

Using qualitative methods, the National Alliance on Mental Illness of New York City (NAMI-NYC Metro) examined New Yorkers' knowledge of the benefits mandated by Timothy's Law, their access to these benefits and their experience seeking mental health services. The study aimed to expand on the existing literature and inform implementation of the federal parity law, which has the potential to enhance access to mental health services for 113 million Americans.

Qualitative study design

Confidential, in-depth, semistructured telephone interviews were conducted for the study. Recruitment flyers were placed in the offices of high-volume mental health offices and clinics and in hospitals in New York City's five boroughs. Recruitment was also conducted via listings in the NAMI-NYC Metro newsletter. Fifty-four employed individuals were interviewed from October 2008 to May 2009; 32 were adults with mental illness and 22 were parents of children with mental illness. All employees had health insurance coverage issued in New York State from a fully insured company. Of the 54 participants, 37 (69%) were eligible for full parity coverage—that is, they were employed by a company with more than 50 employees and the law covered their biologically based diagnosis or their child's biologically based diagnosis or emotional disorder. The rest were employed by a fully insured company with fewer than 50 employees or had a diagnosis that was not covered by the law.

Through repeated review of participant responses to open-ended questions, we identified and revised themes. Coding trees were developed from each theme. We determined codes by sorting participant responses into categories on the basis of common subthemes. All coding was done independently and then compared. Agreement among all coders was necessary before a theme was included in the analyses, and agreement between at least two coders was necessary to code a response.

Recurrent themes

Seventeen of the 37 interviewees who were entitled to full parity coverage were aware of the parity extension of their outpatient benefits. Of the 20 who were unaware, 12 reported the preparity limit on their benefits, seven did not know their benefits coverage, and one response was missing. Four of the ten participants who were eligible for full parity coverage and reported having used inpatient services were aware of the extension of their inpatient benefits, four reported the preparity limit on coverage, and two did not know their coverage. Few employees had accurate knowledge of the law's parity provision.

A recurrent theme in the interviews was frustration with what interviewees regarded as the health plan's unclear or incomplete communication about parity mental health benefits. Interviewees who called their health plan reported that its phone representatives either did not know about Timothy's Law or gave incomplete or vague information about the law. For example, one employee stated, "When you call, a lot of times you get incorrect information, especially if you don't mention that you know about Timothy's Law. So when they quote your coverage they've been quoting it wrong. . . . And if you keep asking [health plan name] and you tell them '[My daughter] is covered under Timothy's Law,' then they were, like, 'Oh, okay, well then she does have unlimited coverage if it's medically necessary.' "

The health plan's written notices about updated mental health benefits were repeatedly reported to contain incomplete information, to lack a description of the full parity benefit, and to be generally uninformative. For example, one employee stated, "I believe [the mental health benefits notice] was a very short and rather simple explanation, which basically said the law had been changed and the upshot of the law was that mental health services had to be covered to the same degree as other medical conditions without going into a whole lot of detail, including without differentiating between biologically and non–biologically based conditions. So the reason I say I thought it was very clear and easy to understand is because I think it had a very limited amount of information. It was just very general, saying that they had to cover mental health on the same basis as other conditions. . . . Ultimately, I guess I misunderstood it, because I didn't realize that the limit on mental health services wouldn't apply to my daughter, but I believed that I understood it well."

Many interviewees also reported that they felt they needed to apply significantly greater effort to gain access to information on their mental health coverage compared with information on their medical-surgical coverage. For example, one employee compared mental health benefits information to a "black box," and another stated, "There's not as much information provided by [health plan] about how to go about accessing mental health benefits. They give us a lot of literature about the physical health benefits but not so much about the mental health."

Difficulty finding a high-quality mental health care provider in the health plan's provider network was another recurring theme in the interviews. For example, one employee stated, "And it really has been hard to find the right people and when we find them, they are precious to us. They are never in-network. You know, for every other health care, we use people who are in-network. Even if [the health plan] claims to be offering parity, by not providing in-network doctors then in a sense it is not really offering anything close to being equal." This perceived barrier to care was particularly prevalent among parents of children with mental illness. For example, one parent stated, "I've been calling when my son first had his illness. I researched my insurance network, and I did some cold calling, leaving messages, and for the most part, eight out of ten of the doctors would say, 'No, I'm not seeing any more patients.' Or 'I'm only going to see your child to prescribe medication. That's it. You'll have to look for somebody else to provide therapy.' "

Furthermore, employees repeatedly expressed frustration with the network provider lists, which included providers who were no longer accepting

members' health insurance. Parents and consumers alike cited a lack of information about mental health providers' qualifications as a barrier to care. Finally, employees reported that although their primary care providers could provide referrals to general medical specialists, they could not as readily make referrals to mental health providers.

Some interviewees perceived more aggressive managed care of their mental health benefits than their medical-surgical benefits, particularly in regard to preauthorization and medical necessity criteria. Reports regarding preauthorization were mixed. Some interviewees who reported having a preauthorization requirement for health services stated that the requirement for mental health care was not comparable to that for general medical care. Although some interviewees reported that a greater number of visits were preauthorized at a time, others perceived more aggressive management and reported a significantly smaller number of visits approved after implementation of Timothy's Law. For example, one stated, "They're giving me a harder time to approve an increase in the visits, more paperwork for the provider to get reimbursed for increased visits and to justify why I need more visits. They haven't officially denied services, but they delay in approving mental health visits." Interviewees reported frustration with the lack of information on criteria for medical necessity of inpatient care. Consumers and parents reported that denials of care on grounds of medical necessity were often inconsistent with hospital mental health providers' assessment of the necessity of the child's or consumer's treatment.

Implications

Our qualitative study of consumers' experience in New York uncovered a number of barriers to accessing mental health benefits and high-quality mental health services that are likely to be prevalent and therefore likely to prevent successful federal parity implementation. The results of this study suggest that it should be replicated with a larger sample and a more representative sampling strategy.

First and foremost, we found that most of the mental health consumers and parents of children with mental illness we interviewed were not aware of their extended benefits. These findings are consistent with Hsu and colleagues' (10) recent examination of beneficiaries' knowledge of their Medicare Part D drug benefit, which found that only 40% of elderly Medicare Advantage enrollees with a Part D drug benefit were aware that their drug plan included a coverage gap. In a 2009 issue of *Psychiatric Services,* Rosenbach and colleagues (7) noted that according to reports from mental health providers, consumers did not know their benefits coverage either before or after the passage of the California parity law. Our findings, to the contrary, showed that most individuals interviewed had been informed of their coverage limits before the parity law but were unaware of their current parity benefits. Furthermore, the consumers in our study reported receipt of incomplete and vague information about mental health coverage from their health plan, which they cited as a significant barrier to their becoming knowledgeable about and using their benefits.

Two issues identified in our study require further investigation and appropriate action. First is the reported disparity in the effort necessary to find high-quality in-network mental health providers compared with other in-network medical professionals. Second is consumers' expressed frustration with stricter managed care practices. For example, although the federal law mandates parity in inclusion criteria for the provider network, it may be necessary to monitor this provision to ensure access to high-quality mental health services. Furthermore, although federal law specifically mandates equality in the managed care techniques applied to mental health and medical-surgical benefits, an ongoing mechanism for enforcing compliance should be established.

Education efforts at both federal and community levels are required to ensure that the 113 million Americans affected by the federal parity law are alerted to their extended benefits and able to access them. Accordingly, at the federal level, it is imperative to develop standards for comprehensive written and verbal communications from health plans about mental health benefits and to monitor these communications for compliance with the standards. At the community level, mental health providers and advocates must educate clients and community members about parity benefits. Behavioral health agencies should provide comprehensive benefits information to community members on their Web sites or in newsletters. Human resources professionals should develop programs to educate all employees regarding extended parity benefits while simultaneously addressing workplace stigma. Finally, it should be noted that the reported shortage of mental health providers, particularly those who treat children, is a national problem that could further restrict access to mental health care as consumers and parents seek to utilize their extended benefits.

References

1. Pacula RL, Sturm R: Mental health parity: much ado about nothing? Health Services Research 35:1601–1608, 2000
2. Rosenbach M, Lake T, Young C: Effects of the Vermont Mental Health and Substance Abuse Parity Law. Rockville, Md, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2003
3. Bao Y, Sturm R: Effects of state mental health parity legislation on perceived insurance coverage, access to care, and mental health specialty care. Health Services Research 39:1361–1377, 2004
4. Goldman HH, Frank RG, Burnam MA, et al: Behavioral health insurance parity for federal employees. New England Journal of Medicine 354:1378–1386, 2006
5. Azrin ST, Huskamp HA, Azzone V, et al: Impact of full mental health and substance abuse parity for children in the Federal Employees Health Benefits Program. Pediatrics 119:452–459, 2007
6. Barry CL, Frank RG, McGuire TG: The costs of mental health parity: still an impediment? Health Affairs 25:623–634, 2006
7. Rosenbach ML, Lake TK, Williams SR, et al: Implementation of mental health parity: lessons from California. Psychiatric Services 60:1589–1594, 2009
8. Snider EL: Awareness and use of health services by the elderly: a Canadian study. Medical Care 18:1177–1182, 1980
9. Castellblanch R, Abrahamson DJ: What focus groups suggest about mental health parity policymaking. Professional Psychology: Research and Practice 34:540–547, 2003
10. Hsu J, Fung V, Price M, et al: Medicare beneficiaries' knowledge of Part D prescription drug program benefits and responses to drug costs. JAMA 299:1929–1936, 2008