



# Parity Mental Health Benefits:

What is the Impact on  
Client Access to Services  
and on Systems of Care?

PRACTICE RESEARCH NETWORK



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# Background

Although great advances have been made in the past few decades in the prevention and treatment of physical diseases, mental illness and mental health have not been given the same priority in terms of research to advance prevention and treatment approaches. Landmark findings from the World Health Organization's Study of Disease Burden indicated that the impact of mental illness on overall health and productivity in the United States and throughout the world is profoundly under-recognized. Today, in established market economies such as the United States, mental illness is the second leading cause of disability and premature mortality, accounting for more than 15 percent of the overall burden of disease from *all* causes. One in four families has at least one family member with a mental disorder (World Health Organization, 2006).

Even as the scientific basis for treating mental illness advances and promising treatments are developed, there continues to be widespread fear and stigma associated with diseases of the mind that limit access and utilization of effective interventions. Another critical factor influencing the quality of mental health care services is the patchwork arrangement of organization and financing of those systems of care (U.S. Department of Health and Human Services, 1999).

Millions of Americans with mental disorders do not have equal access to health insurance. Many health plans discriminate against people with mental illness by limiting mental health and substance abuse health care by disqualifying coverage for certain mental disorders and imposing lower day and visit limits, higher co-payments and deductibles, and lower annual and lifetime spending caps. These laws discriminate against children and adults whose illnesses can be as disabling as those specified in the laws, but do not fit neatly within the statutes' criteria. Adults excluded from protection under these laws include those who have multiple personality disorders, anorexia nervosa and bulimia, post-traumatic stress syndrome, and substance abuse disorders. Children with serious emotional disturbances and substance abuse disorders are often excluded.

Currently, 34 states have made into law some form of mental health parity. While falling short of the desired policy of comprehensive coverage for mental disorders in all health insurance plans, these incremental advances are a clear response to the devastating personal and economic burden of untreated mental illness (National Mental Health Association, 2005; National Alliance on Mental Illness, 2006).

In 2001, mental health parity was implemented in health benefit plans for all federal employees through the Federal Employee Health Benefits Plans (FEHB). A large-scale study of claims data has been conducted to assess the impact of this policy change. Study findings indicate that the implementation of parity in insurance benefits for behavioral health care, combined with care management, improved insurance protection without increasing total costs of care (Goldman, et al., 2006). This study clearly supports efforts to advance mental health parity legislation at the federal level.

# Social Workers and Mental Health Parity

The National Association of Social Workers has long supported the policy of mental health parity, in which both public and private insurance plans provide comparable coverage for mental health conditions as is provided for physical health conditions (National Association of Social Workers, 2006). The Association has worked in coalitions to advance the adoption of mental health parity laws at both the state and federal levels.

To better understand the impact of mental health parity on access to social work services and care management, the Center for Workforce Studies conducted a survey to describe social workers' practice by setting, caseload size, involvement in health plans, participation on network panels, and ability to accept new patients. Social workers were also asked to systematically select a client from their caseload and provide detailed clinical data and data regarding the client's insurance coverage, treatments provided, treatment access issues, and administrative burdens associated with insurance documentation and reporting.

Because of previous successful research collaborations with the American Psychiatric Association and the American Psychological Association, the parity project was designed to use parallel study instruments and data collection methods among three cohorts of social workers, psychiatrists, and psychologists. It was expected that data collected from the three major mental health provider groups could be combined to provide a more comprehensive picture of the impact of the FEHB parity plans. Although the combined study analysis and findings are currently in process, the social work study has been completed and those findings are included in this report.

# Study Methods

A survey sample of 500 was randomly selected from NASW regular members (N=5,007) who reside in zip codes in the Washington, D.C. Primary Metropolitan Statistical Area, a geographic region with a high rate of participants in FEHB plans. The questionnaire was designed to gather general practice information about participation in insurance plans, as well as information about a specific client's age, insurance coverage, psychiatric diagnosis, and length of treatment. Client selection was designated from all clients seen in the previous typical work week, and no client identifying information was requested in order to protect confidentiality.

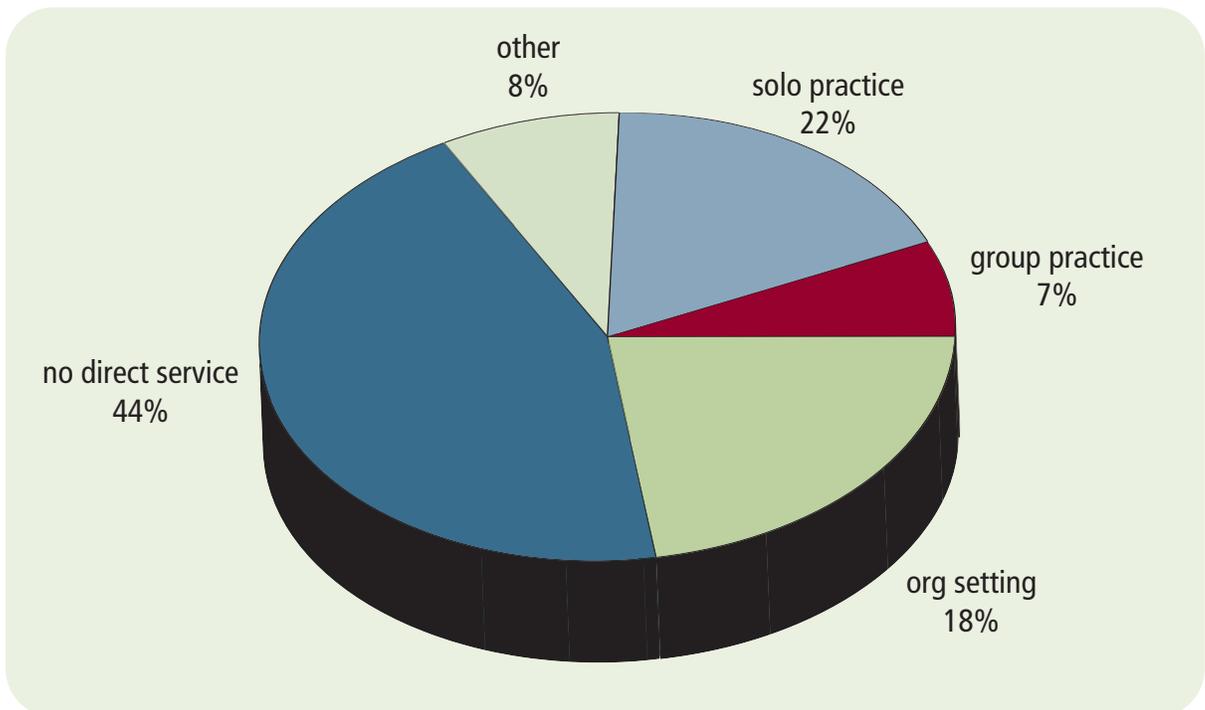
Data were collected via mail survey between April 22 and June 13, 2005. A total of 302 usable responses were received, for a 60 percent response rate. Most of the data reporting is based on the 169 respondents indicating they currently provide services to clients. Percentages based on these 169 responses are subject to a margin of error of  $\pm 7.3$  percent at the 95 percent confidence level. Percentages calculated on smaller tabulation bases are subject to more statistical variability. Findings should only cautiously be generalized to the national population of NASW members, if at all.

# Key Findings

- 1 NASW members provide services in a range of organizational settings, both private practice and agency based, and offer significant client services to those covered by both private and public insurance programs.

One hundred thirty-three (133) of the survey's 302 respondents (44%) indicated they do not currently provide services to clients. Figure 1 shows that the balance of the 169 "practitioners" are found primarily in a solo (22%) or group (7%) independent/private practice setting, or in an organizational setting (e.g., mental health services, primary care [18%]). Eight percent report some other practice setting, for example, school, prison, etc.

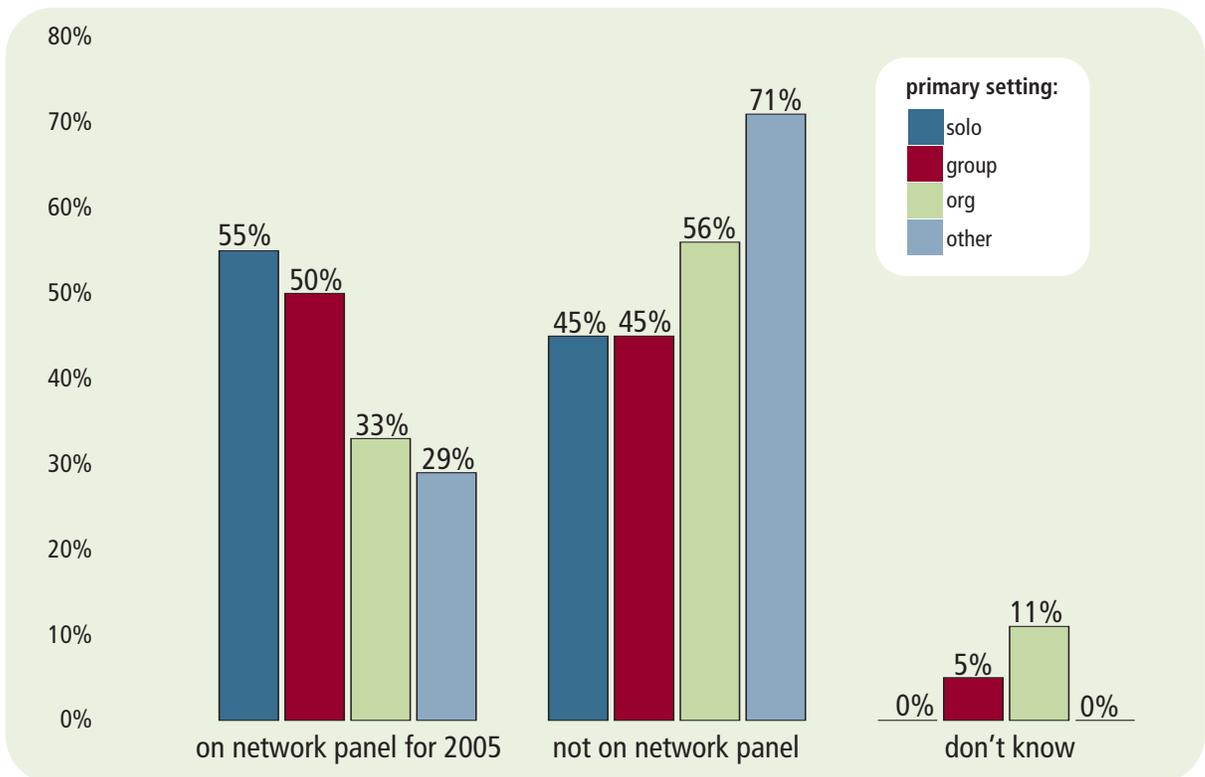
FIGURE 1. PRIMARY PRACTICE SETTING



(BASE: 302 RESPONDENTS)

A significant number of social workers report that they are currently participating in private or public insurance networks. Forty-four percent (44%) of practitioners overall indicated that they belonged to a health plan network or a provider panel for 2005. A majority of those in solo or group private practice are in networks or on panels, compared with only a third of those in organizational settings, and 29 percent of those in other settings (Figure 2).

**FIGURE 2. MEMBERSHIP ON NETWORKS/PROVIDER PANELS BY PRIMARY SETTING**

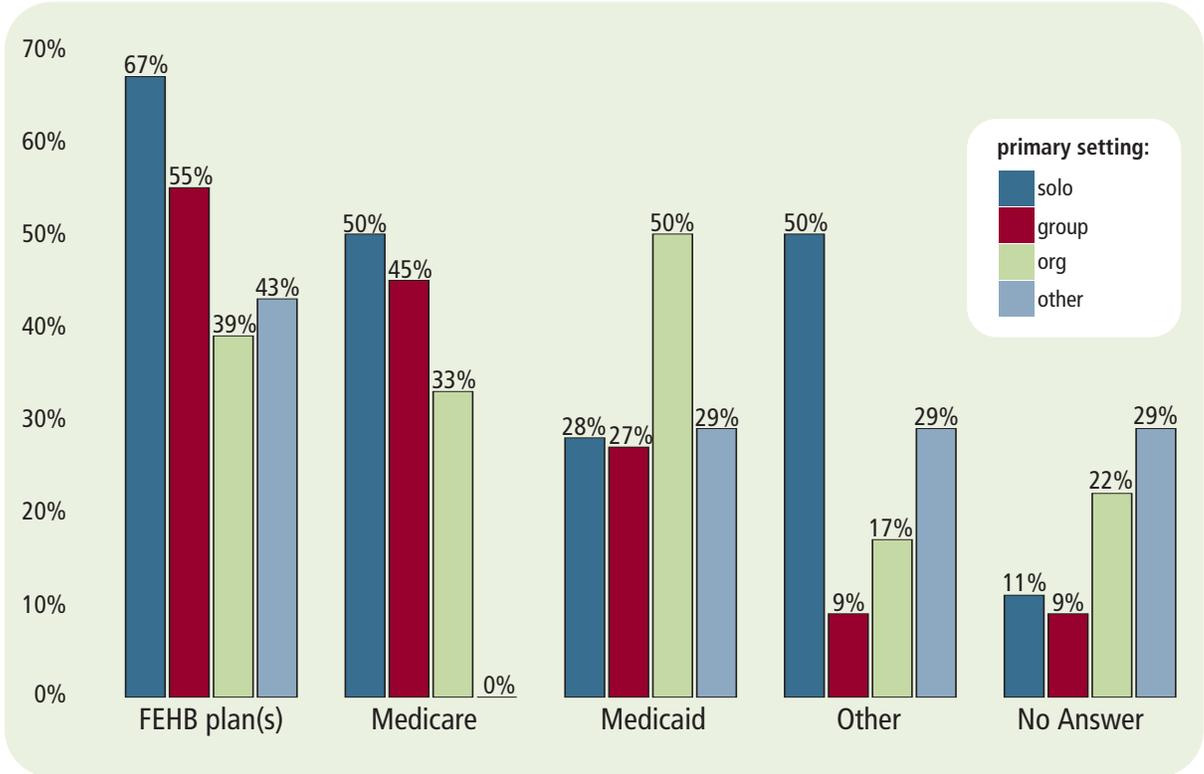


(BASE: 169 PRACTITIONERS)

The majority of social workers who participated in networks for 2005 were members of one or more FEHB plans, including high levels of involvement with Blue Cross/Blue Shield. Other FEHB plans reported included Aetna, Kaiser, GEHA, MD-IPA, and Mail Handlers Benefits Plan. Forty-two percent (42%) were providers for Medicare, 34 percent for Medicaid, and 32 percent for other, non-FEHB, private insurance plans.

Figure 3 shows that those in solo or group practice are more likely than others to be network social workers for FEHB plans, while those in organizational settings are most likely to be associated with Medicaid.

FIGURE 3. NETWORK PLANS BY PRIMARY SETTING



(BASE: 74 PRACTITIONERS)

Respondents were also asked if they had immediate openings for new clients in FEHB, non-FEHB private plans, and public insurance plans, as well as if they were willing to accept new clients covered by these plans. Table 1 shows that the responses indicate differing levels of availability of openings for clients depending on insurance coverage.

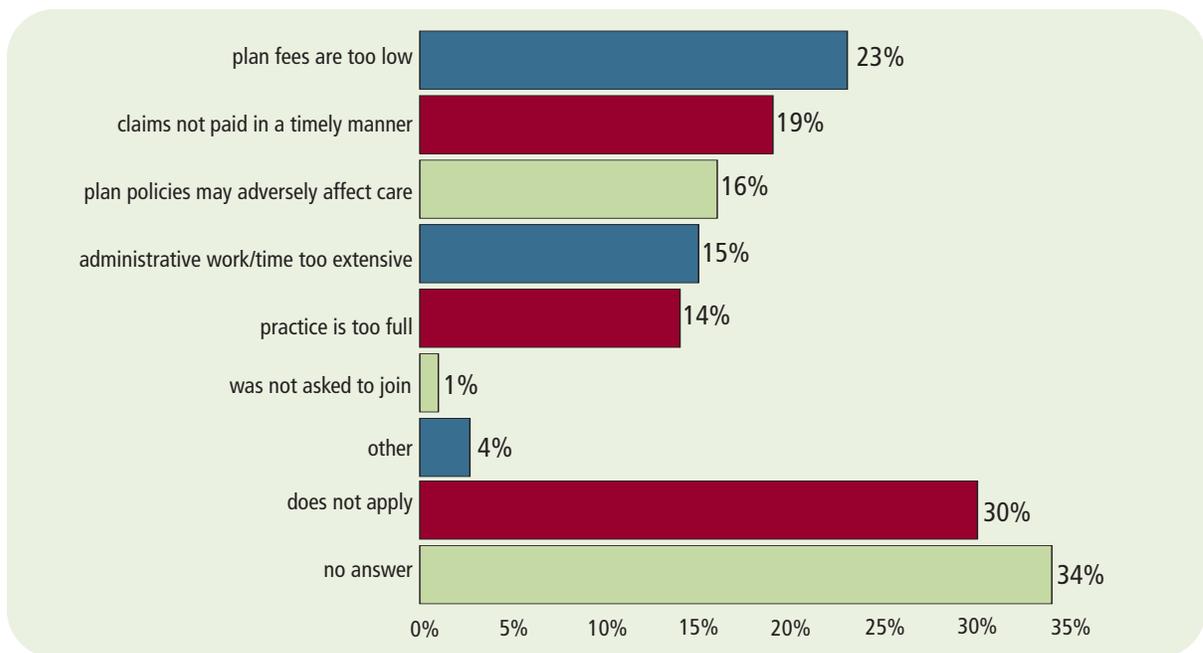
TABLE 1. PLAN STATUS (FOR EACH HEALTH PLAN LISTED BELOW, PLEASE INDICATE IF YOU.....)

	are a network social worker for 2005	currently offer services to clients in this plan	have immediate openings for new clients in this plan	will accept new clients in 2005
<b>ALL FEHB plans</b>	57%	64%	46%	57%
<b>Medicare</b>	42%	38%	24%	30%
<b>Medicaid</b>	34%	28%	16%	20%
<b>Other</b>	32%	34%	22%	31%

(BASE: 74 PRACTITIONERS)

Respondents currently on provider panels were asked for their reasons for not accepting new clients (Figure 4). Of those 74 currently on provider panels, 36 percent gave one or more reasons for why they are not currently accepting clients from the network or panel. The leading reason given, “plan fees are too low,” was cited by 23 percent of respondents, followed by “claims not paid in a timely manner” (19%), “concerned that plan’s care management policies may adversely affect care” (16%), “administrative work/telephone time is too extensive” (15%), and “practice is too full” (14%). Thirty percent said the question does not apply, and 34 percent did not answer.

FIGURE 4. REASONS FOR NOT ACCEPTING NEW CLIENTS

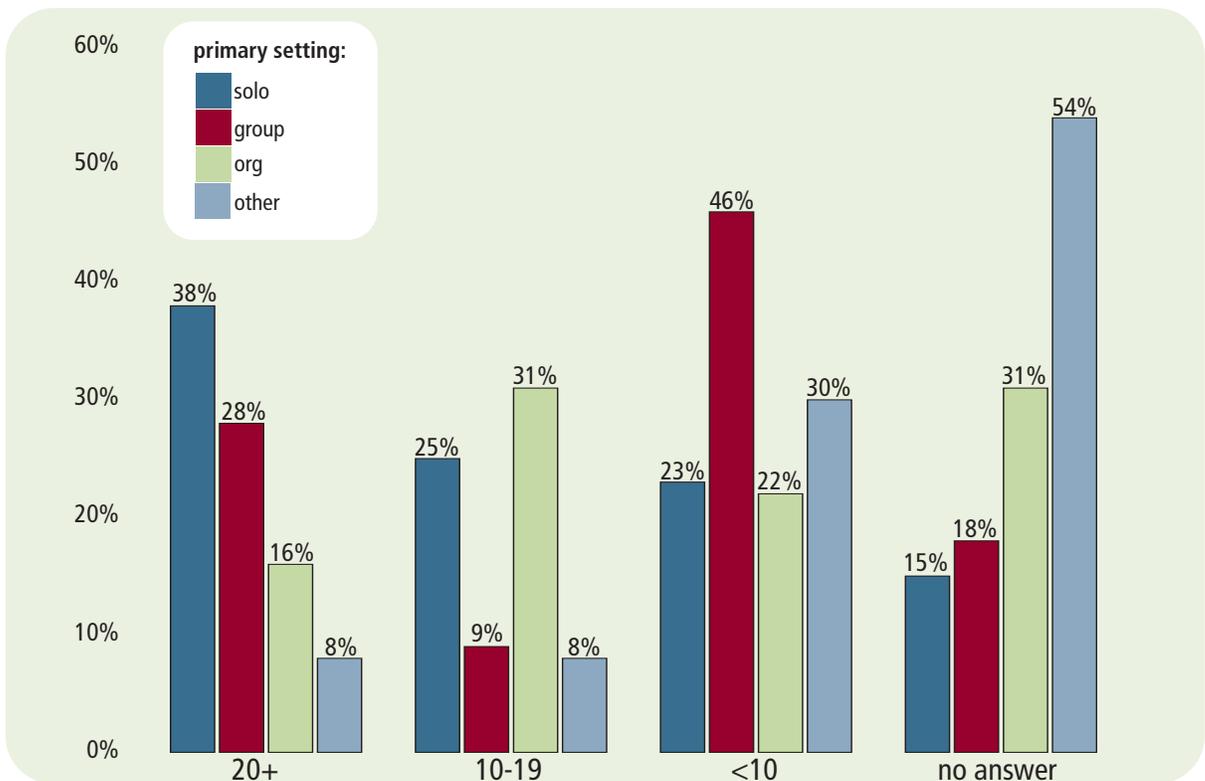


(BASE: 74 PRACTITIONERS)

- 2 Client caseloads and payment sources varied depending on the service setting with significant numbers of clients self-paying for their social work services.

The 169 practitioners were asked to consult their 2005 appointment books and count the number of clients treated in the latest typical work week, with multiple visits from the same client counting as only one client. The mean across all practitioners was 14.8 clients seen in that week, with 25 percent indicating 20 or more, and 27 percent fewer than 10. Figure 5 shows caseloads to be higher than average for practitioners in solo private practice, and below average for those in group practice and other (non-organizational) settings.

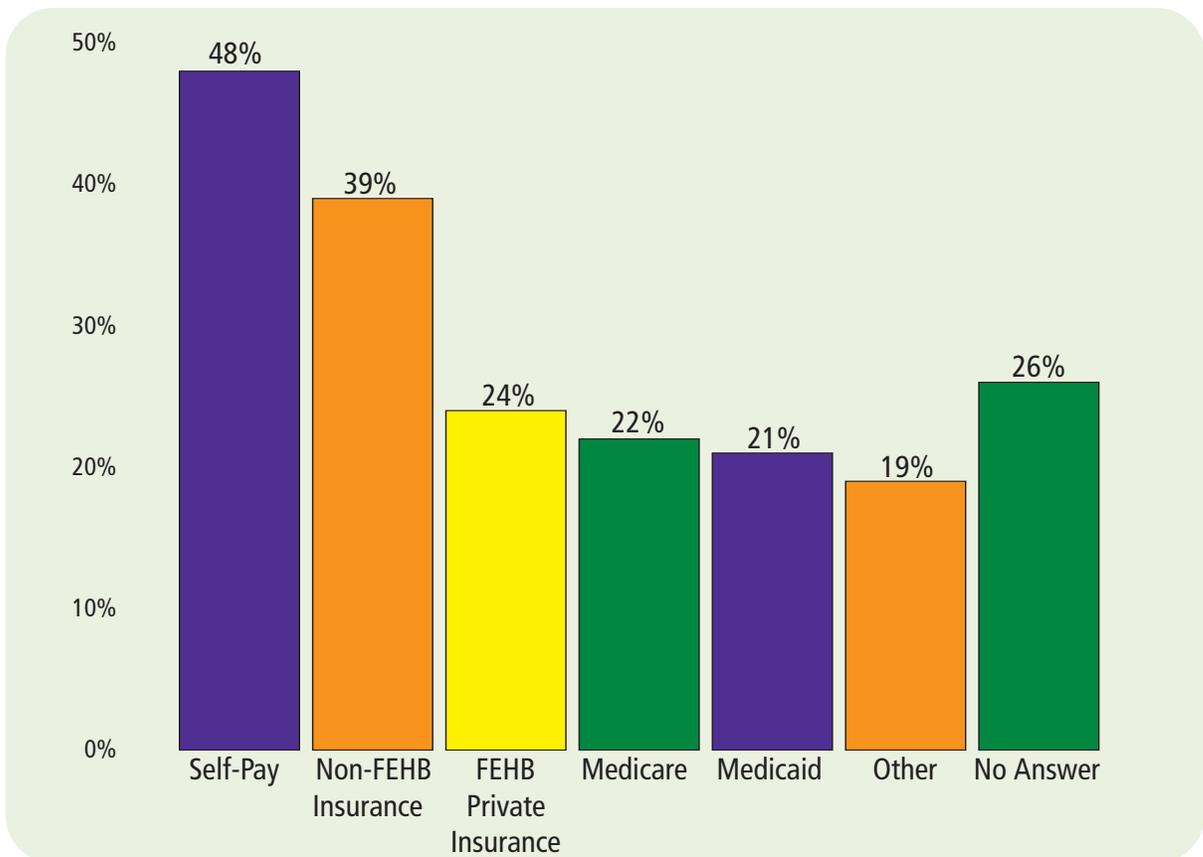
FIGURE 5. NUMBER OF CLIENTS TREATED IN TYPICAL WEEK BY PRIMARY SETTING



(BASE: 169 PRACTITIONERS)

Respondents were also asked to report their sources of payment in a typical week in order to gauge the range of clients seen who were covered by different insurance plans. Significantly, 48 percent of practitioners overall indicated that at least one of their clients in a typical week was self-pay, followed by 39 percent for non-FEHB private/commercial insurance, 24 percent for FEHB private insurance, 22 percent for Medicare, 21 percent for Medicaid, and 19 percent other insurance. The precision of these estimates is diminished by the fact that 26 percent did not answer this question. However, it does suggest that social workers may serve a client base that is not covered by insurance programs.

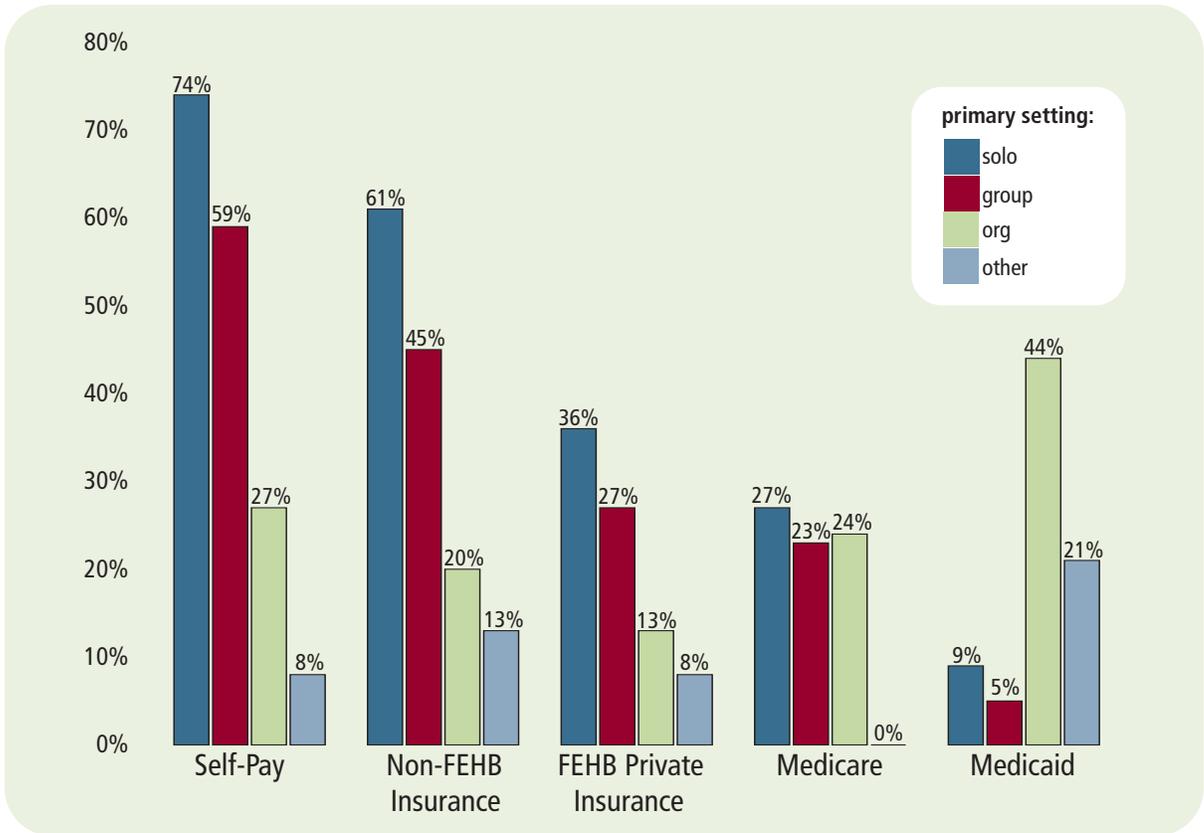
**FIGURE 6. PAYMENT SOURCES IN TYPICAL WEEK**



(BASE: 169 PRACTITIONERS)

That same data analyzed by primary setting show those in group and (especially) solo private practice to be far more likely to handle self-pay clients, while Medicaid is seen most frequently by those in organizational settings (Figure 7).

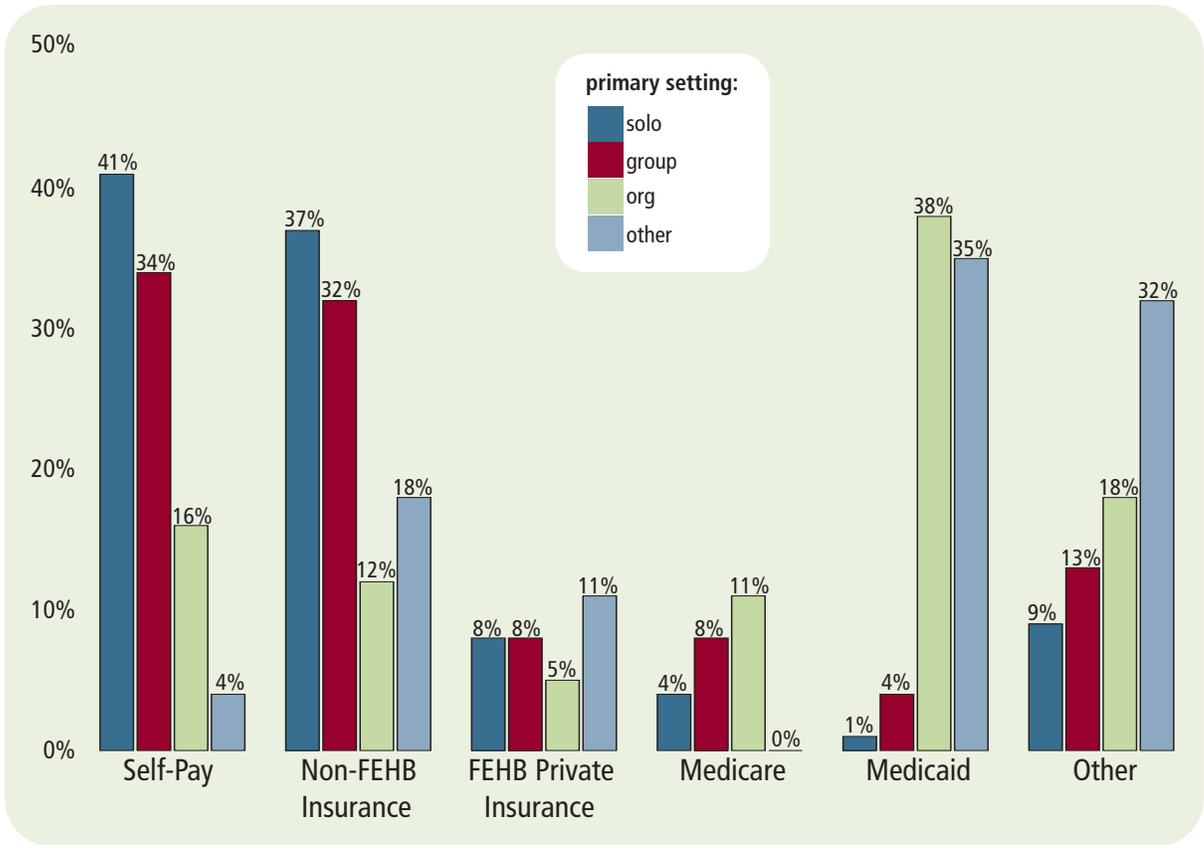
FIGURE 7. PAYMENT SOURCES IN TYPICAL WEEK BY PRIMARY SETTING



(BASE: 169 PRACTITIONERS)

Looking at the same data from a slightly different perspective, 28 percent of those reporting on a typical week indicated that clients were self-pay, 27 percent non-FEHB private/commercial insurance, 8 percent FEHB private insurance, 6 percent Medicare, 16 percent Medicaid, and 14 percent something else. Figure 8 shows self-pay and non-FEHB insurance to be primary sources for those in private practice, while Medicaid is highly important to those in organizational and other settings.

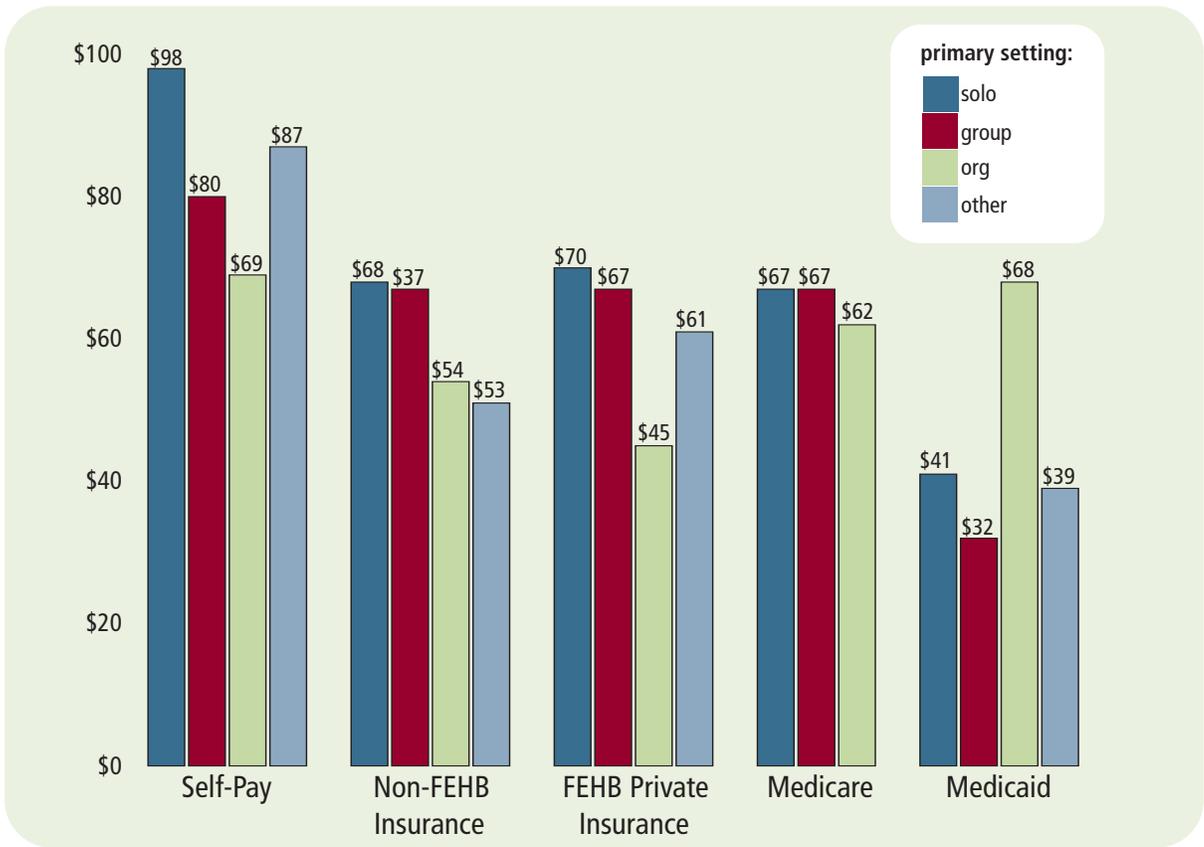
**FIGURE 8. PERCENTAGE OF CLIENTS USING PAYMENT SOURCES BY PRIMARY SETTING**



(BASE: 169 PRACTITIONERS)

Practitioners were also asked to provide their current average reimbursement rate for 45-50 minutes of outpatient individual psychotherapy (CPT 90806) for each payment source (Figure 9). Mean hourly rates are highest for self-pay clients (though not so much for those in organizational settings), and similar for non-FEHB insurance, FEHB insurance, and Medicare. With the exception of those in organizational settings, mean hourly rates are substantially lower than Medicaid rates. These data are of low reliability, however, based in some cases on fewer than 30 reporting respondents.

FIGURE 9. REIMBURSEMENT RATES FOR PAYMENT SOURCES BY PRIMARY SETTING



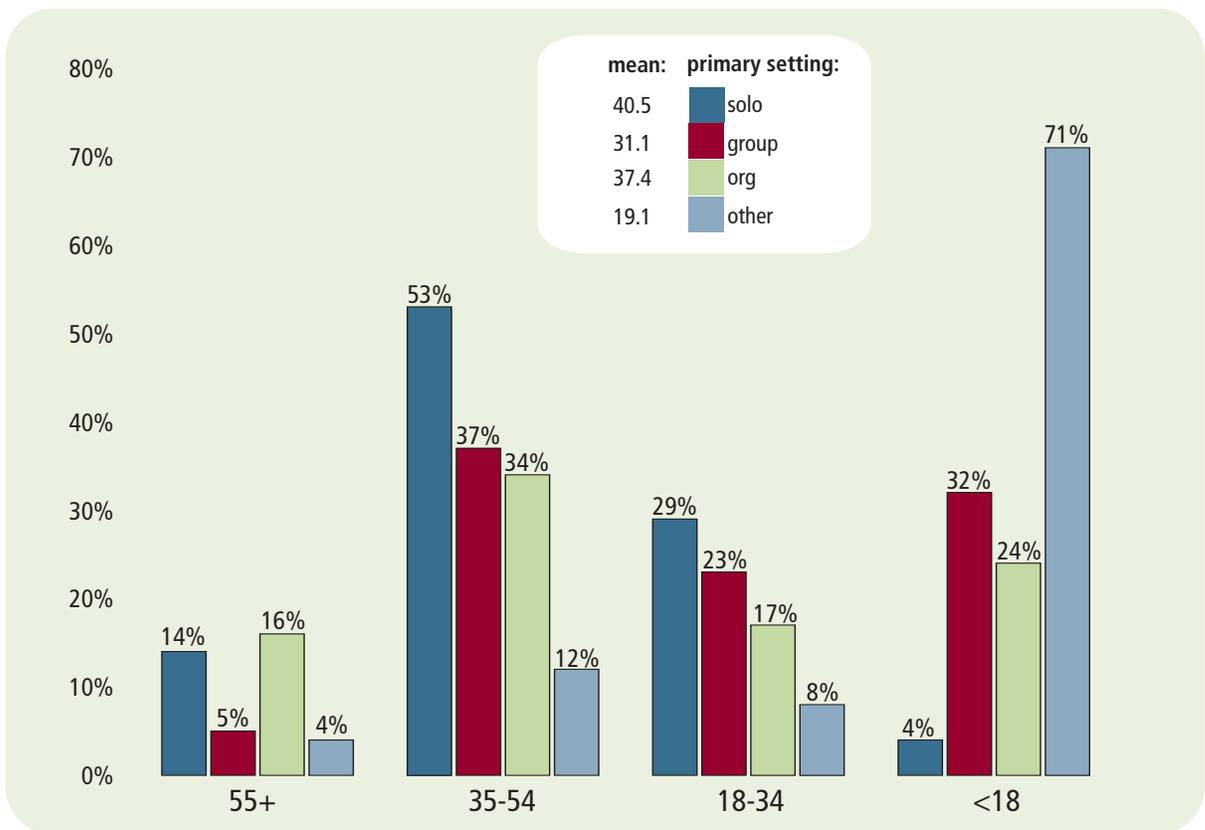
(BASE: 169 PRACTITIONERS)

- ③ Client characteristics such as age, psychiatric diagnosis, and length of treatment varied according to practice setting and insurance coverage.

In order to better assess the impact of mental health parity insurance coverage on client services, the study collected data on an individual client related to their age, psychiatric diagnosis, and length of treatment. Respondents were to select a specific client from the previous typical work week and respond to several questions about the client and services provided. Practitioners were instructed to select the first FEHB client of the week, or if no services were provided to FEHB clients, to select the first non-FEHB client and complete a series of questions.

The mean age of reported clients across all practitioners is 35.4, with 12 percent age 55 or older, 40 percent between 35 and 54, 21 percent between 18 and 34, and 23 percent under 18. Figure 10 shows that clients of social workers in solo private practice are oldest on average (40.5 years), followed by those in organizational settings (37.4) and group practice (31.1). Social workers in other settings appear to concentrate primarily on children, with 71 percent of reported clients under age 18.

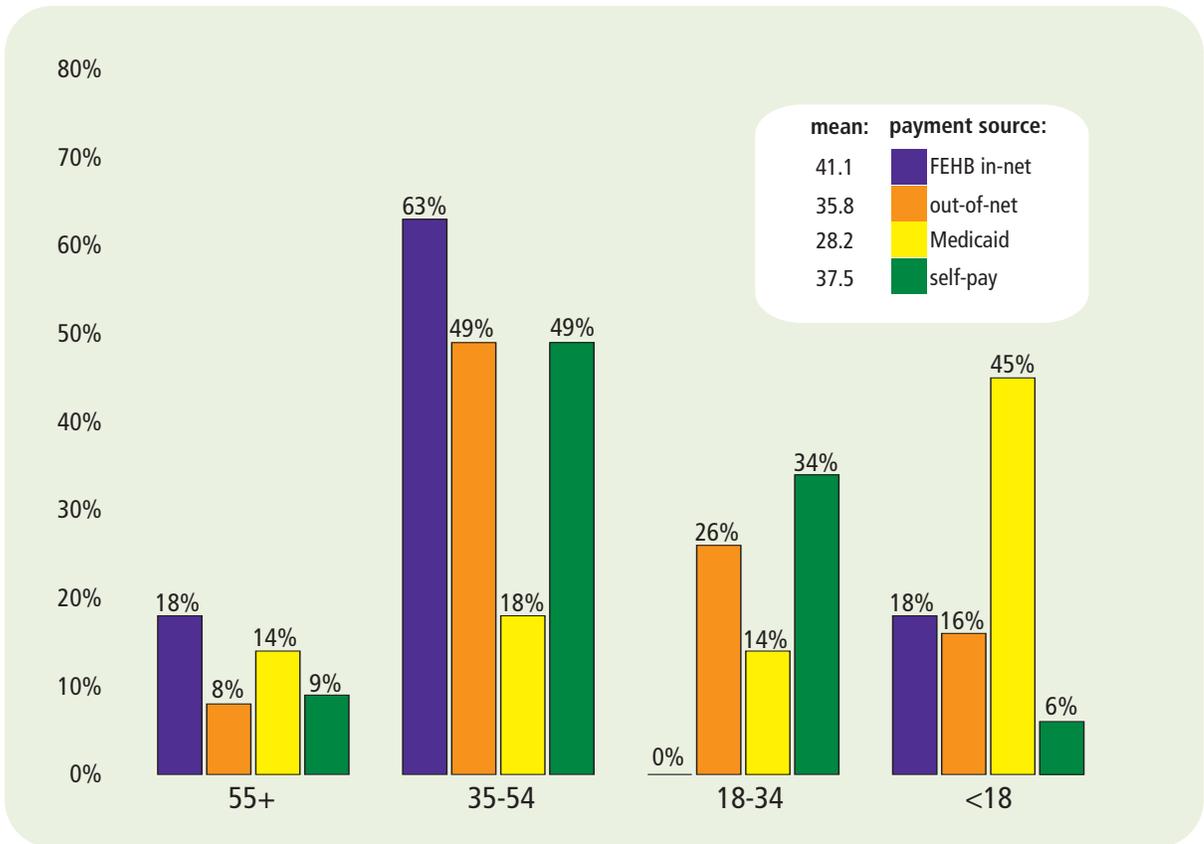
**FIGURE 10. CLIENT AGE BY PRIMARY SETTING**



(BASE: 169 PRACTITIONERS)

Figure 11 shows those in the 35-54 age group most likely to use FEHB payment, those 18-24 most likely to be self-pay, and those under 18 most likely to use Medicaid. A significant number of those in the 35-54 age range also use non-FEHB private insurance or self-pay.

FIGURE 11. CLIENT AGE BY CLIENT'S LARGEST PAYMENT SOURCE

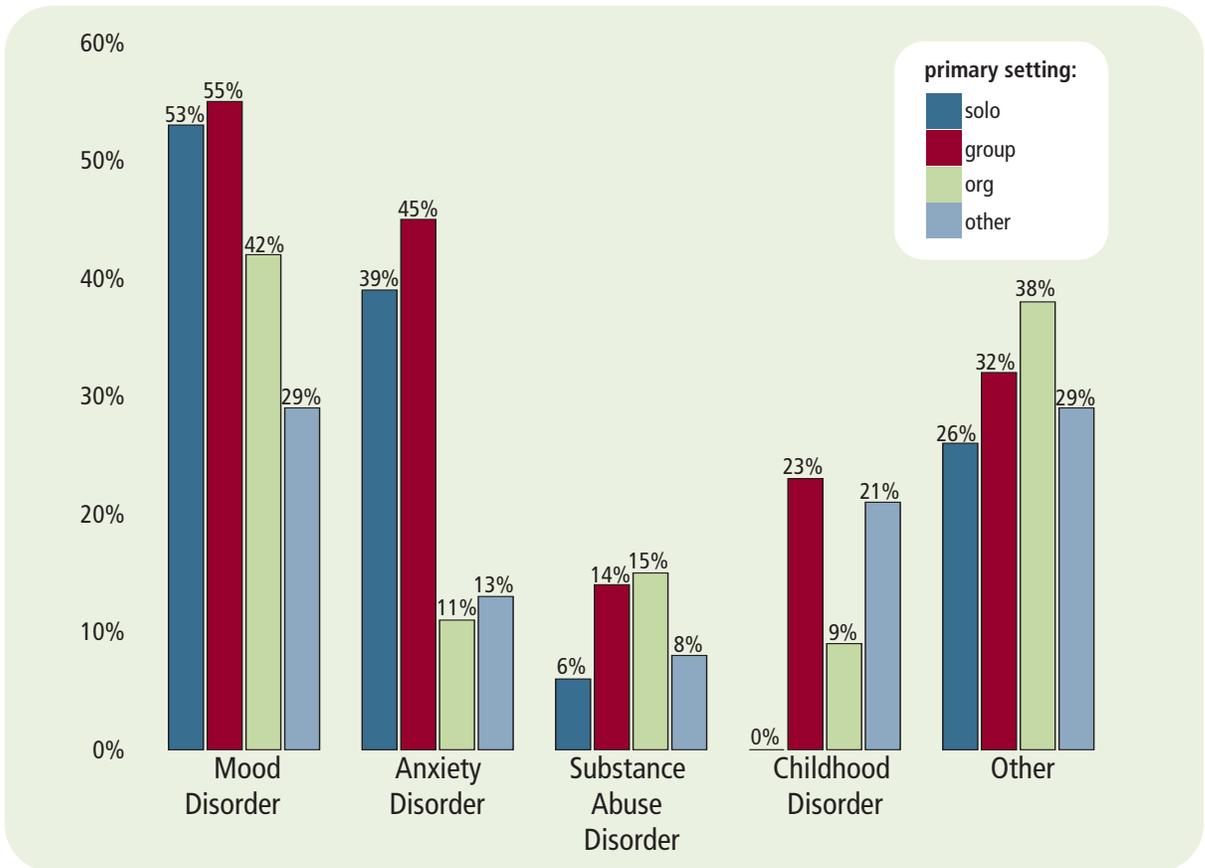


(BASE: 169 PRACTITIONERS)

Respondents were asked to report the psychiatric diagnosis (using DSM-IV classifications), if any, of the client designated for reporting. About half of all reported clients (47%) had a Mood Disorder as part of their psychiatric diagnoses at the reported visit, followed by Anxiety Disorder (27%), Substance Abuse Disorder (10%), Childhood Disorder (9%), and other (31%, led by ADD/ADHD and adjustment disorders).

Mood and Anxiety disorders are more common among those treated by private practitioners than others, while Childhood Disorders are seen most often by those treated in group or other settings (Figure 12).

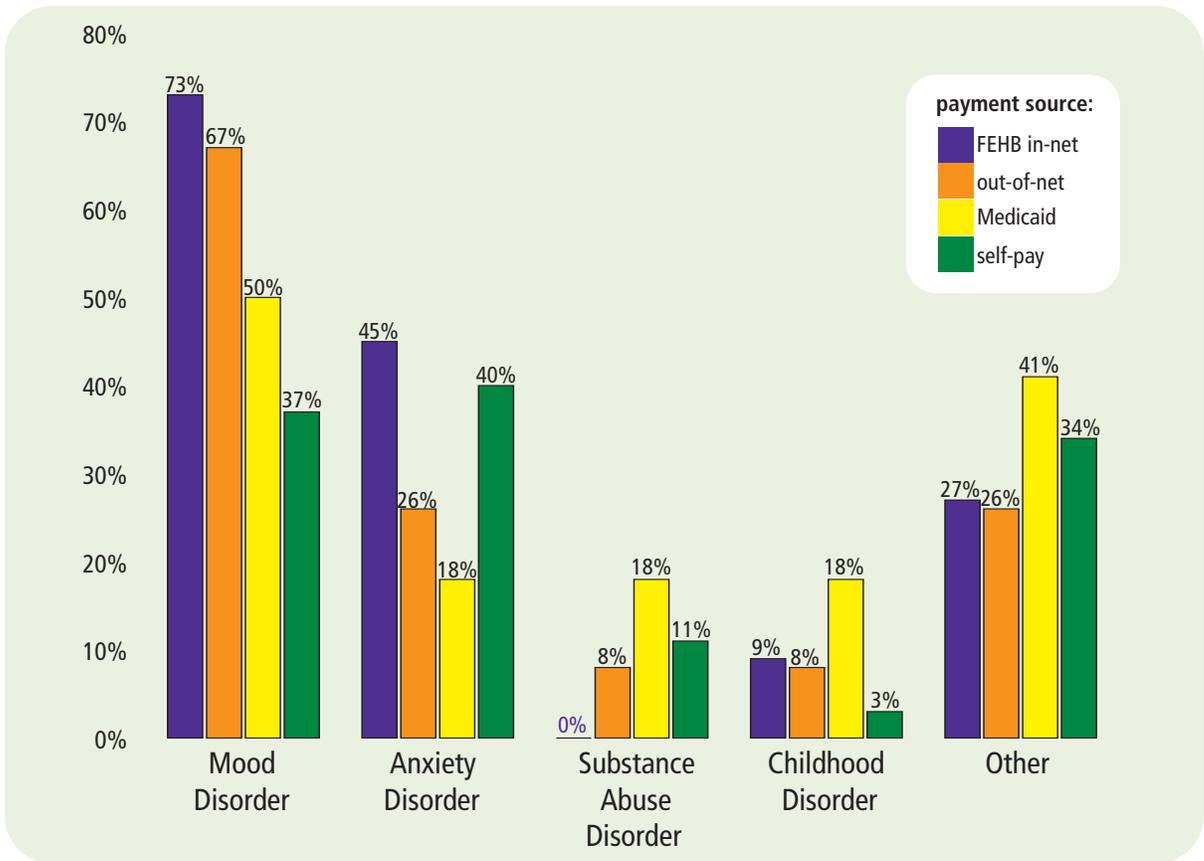
FIGURE 12. CLIENT DIAGNOSES BY PRIMARY SETTING



(BASE: 169 PRACTITIONERS)

Insurance is the largest payment source for those with Mood Disorders; FEHB in-network coverage and self-pay for Anxiety Disorders; and Medicaid for Substance Abuse and Childhood Disorders (Figure 13).

FIGURE 13. CLIENT DIAGNOSES BY CLIENT'S LARGEST PAYMENT SOURCE

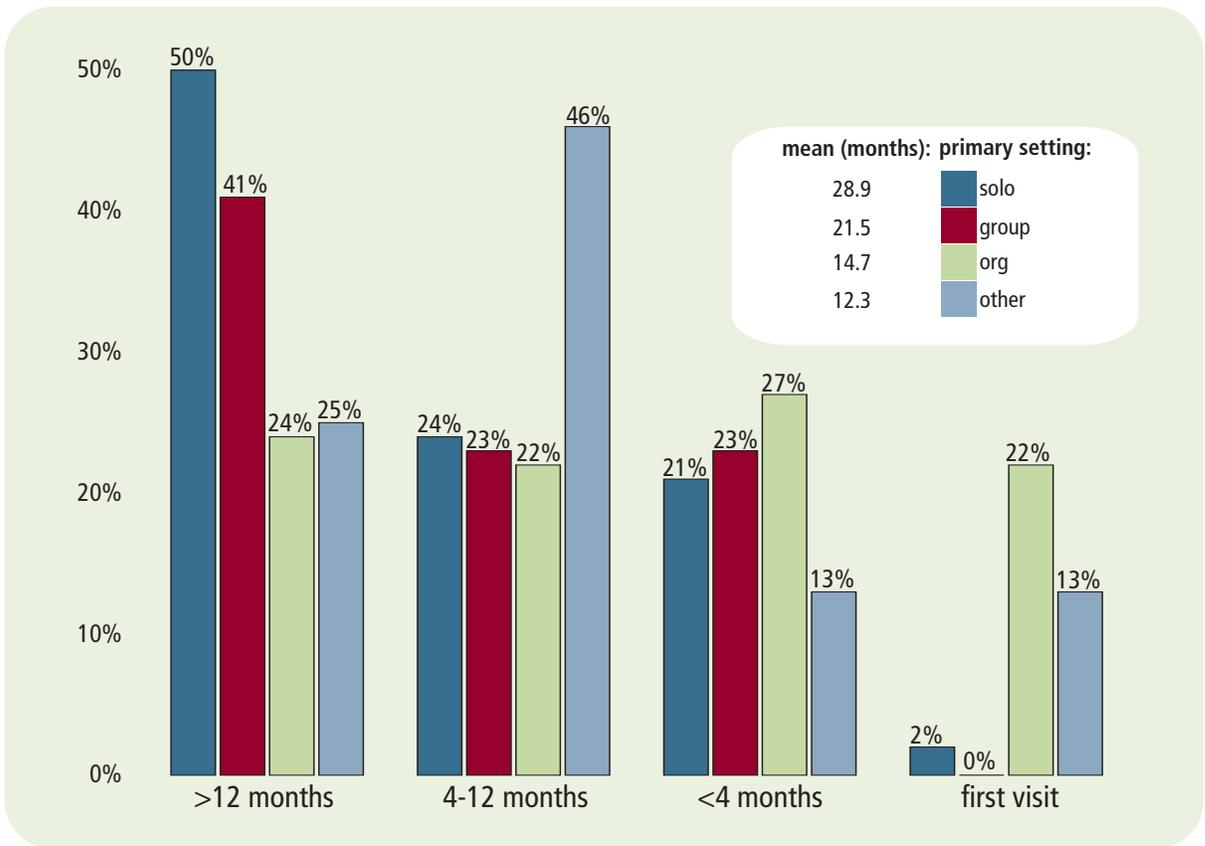


(BASE: 169 PRACTITIONERS)

A question about the length of treatment of the individual client was included to assess the variations in length of care according to service setting and insurance coverage as a possible indicator of differences in access to care. The average time in treatment across all reported clients is 21.5 months, with 37 percent in treatment for more than 12 months, 26 percent for 4-12 months, and 22 percent for less than four months. For 9 percent, this was the reported client's first visit.

Average time in treatment is longest for those in solo practice, and shortest for those in organizational or other settings (Figure 14).

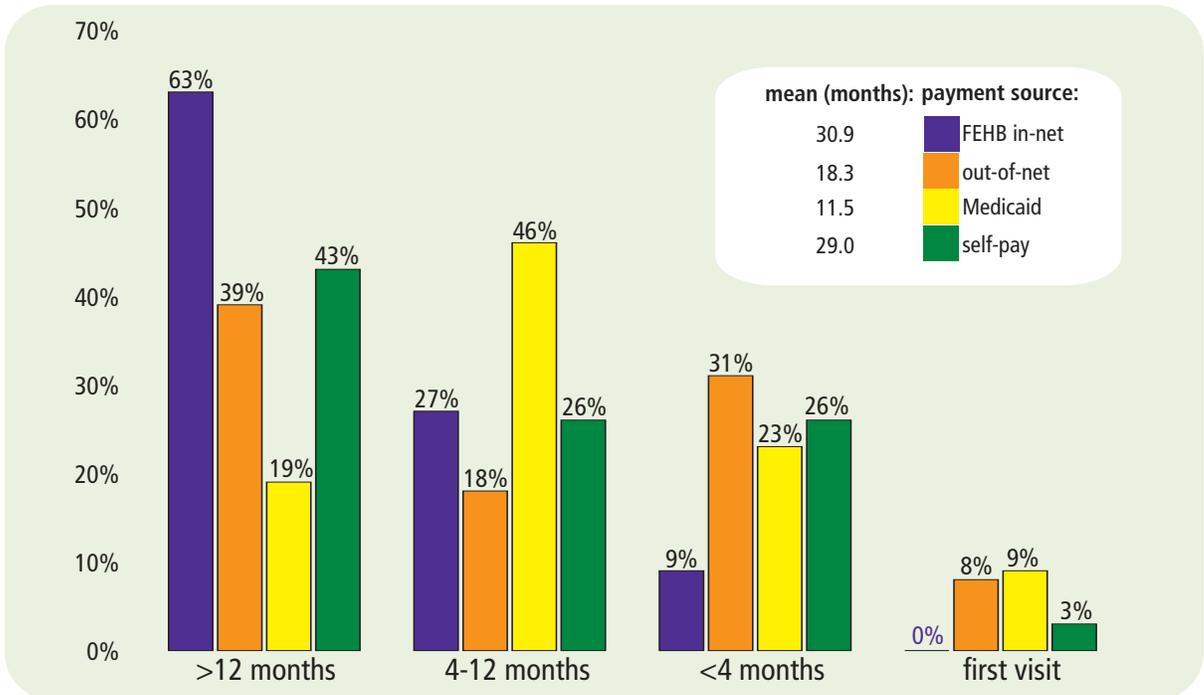
**FIGURE 14. CLIENT TIME IN TREATMENT BY PRIMARY SETTING**



(BASE: 169 PRACTITIONERS)

Figure 15 shows that those whose largest payment source is FEHB in-net or self-pay reported the longest average times in treatment (30.9 and 29.0 months, respectively). Those paying through Medicaid average only 11.5 months in treatment.

FIGURE 15. CLIENT TIME IN TREATMENT BY CLIENT’S LARGEST PAYMENT SOURCE



(BASE: 169 PRACTITIONERS)

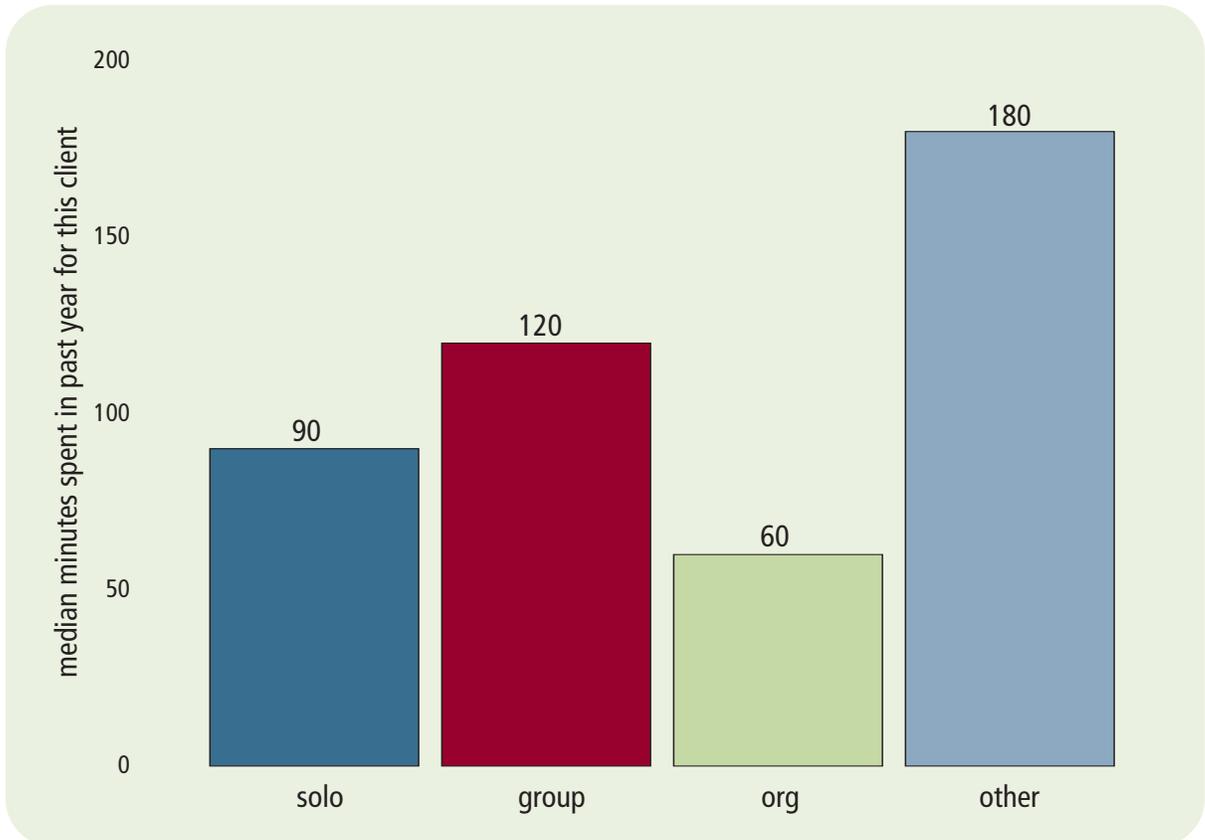
- ④ Administrative burden in terms of completing paperwork and necessary authorizations was lowest in organizational settings and for clients who were self-paying.

One aspect of parity mental health coverage is the practice of insurers to “manage” plan utilization in order to assure appropriate administration of care. Providers are often concerned about the burden of the administrative time required for such plans and their potential to limit time available for direct services to clients. Study findings do indicate variable administrative burdens within practice settings and among payment systems.

To estimate the administrative burden associated with various payment sources, practitioners were asked to estimate (for the reported client) the number of minutes spent in the past year on administrative tasks related to insurance authorization (e.g., completing written treatment reports, completing planning or utilization review forms, and/or obtaining authorizations via phone).

Figure 16 shows that those in organizational settings reported the lightest burden, a median of 60 minutes in the past year, followed by those in solo practice (90 minutes), group practice (120 minutes), and other settings (180 minutes).

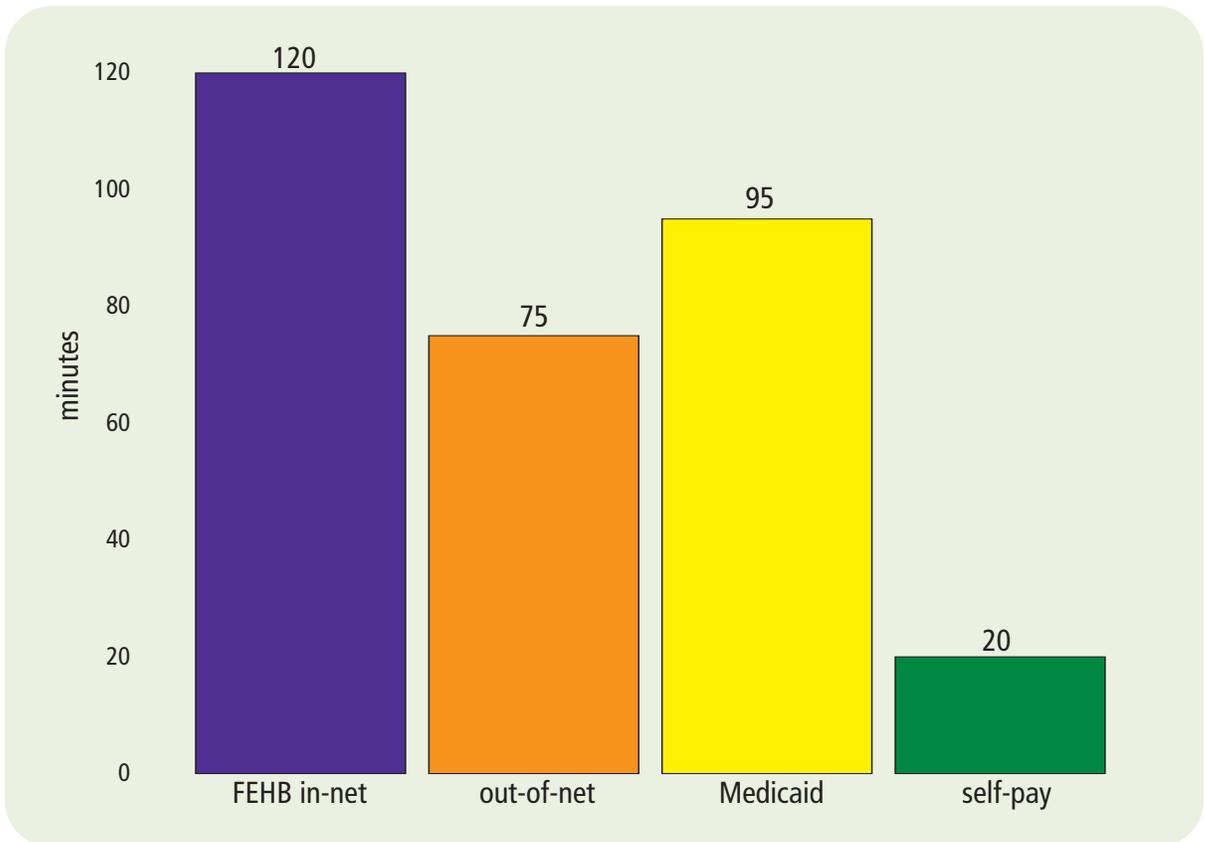
**FIGURE 16. TIME SPENT ON INSURANCE AUTHORIZATION BY PRIMARY SETTING**



(BASE: 169 PRACTITIONERS)

Figure 17 shows FEHB in-network coverage to be the most burdensome major source of payment (median = 120 minutes in past year), followed by Medicaid (95 minutes), out-of-network insurance (75 minutes), and self-pay (20 minutes).

**FIGURE 17. TIME SPENT ON INSURANCE AUTHORIZATION BY CLIENT'S LARGEST PAYMENT SOURCE**



(BASE: 169 PRACTITIONERS)

Respondents were also asked if a range of treatments were indicated for the specific client, but not provided, to assess if primary service setting or insurance coverage was related to the ability to provide needed services. Responses to this question were very low and no reliable findings can be generated from the data.

# Discussion

This exploratory study was designed to provide an understanding of how social workers provide mental health care in both public and private insurance programs, including FEHB parity mental health coverage. Social workers are likely to participate in FEHB insurance plans (57%), and those who are in private solo or group practice are more likely than others to be a network social worker for FEHB plans. In addition, social workers provide services under other private insurance networks (32%), Medicare (42%), and Medicaid (34%), indicating they are a significant mental health service provider for clients in both public and private systems of care. About one third (36%) of respondents indicated that they would not be accepting new clients covered by one of the private or public insurance programs for a variety of reasons, with the most frequently noted reason being reimbursement concerns. This finding points to the need to assess the sufficiency of reimbursement rates for social workers, particularly in programs such as Medicaid.

An unexpected finding was the large number of self-paying clients reported. About half (48%) of all practitioners reported at least one self-paying client in their last typical work week. Those providers in private solo and group practices are much more likely to have clients that self-pay (74% and 59% respectively). This suggests not only coverage gaps in insurance plans related to mental health services, but also that individuals without financial resources have very limited access to care unless they qualify for Medicaid or Medicare coverage.

Findings from the client level data section of the study that examine variables such as the age, diagnosis, and length of treatment of clients raise concerns about access issues for young persons under age 18. Only 23 percent reported on a client 18 years or under. New studies documenting the prevalence and age-of-onset of mental illness highlight the need for early intervention. Unlike most disabling physical diseases, mental illness begins very early in life. Half of all lifetime cases begin by age 14; three-quarters have begun by age 24 (Kessler, et al., 2005). Both public and private insurance programs need to expand coverage for mental health services for children and youth.

Increased emphasis on public health approaches to education and early intervention with children are critical. The length of treatment varied across settings with those in private practice reporting the longest treatment (28.9 months) and those in organizational setting and other settings reporting the shortest treatment (14.7 and 12.3 months, respectively). Looking at payment source and length of treatment confirms that individuals with insurance or with resources for self-pay receive treatment for longer periods (30.9 and 29.0 months, respectively), while those qualifying under Medicaid have the briefest period of treatment (11.5 months). This further suggests unequal access to care among those who are currently receiving services, and does not fully capture the lack of access experienced by those who do not qualify because of coverage gaps, lifetime caps, and other limitations imposed by private and public insurance programs.

Although the time estimates of the administrative tasks related to collecting payments from various sources did not seem overly burdensome, there was considerable variation according to practice setting, with those in “other” settings reporting 180 minutes per client in the past year, contrasted to those in solo private practice who reported 90 minutes per client in the past year. Those in organizational settings (that serve more clients under public programs) have the lightest administrative burden which suggests that public insurance may have less administrative burden than private insurance. This differential needs to be explored and documented in future studies.

In summary, social workers are significant providers of mental health services under a recently enacted federal employee mental health parity insurance plan (FEHB), as well as other private insurance plans, Medicare, and Medicaid. Further exploration is needed to document limits on access to care, barriers to effective intervention, and the longer-term impact of mental health parity coverage.

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