Navigating Health Insurance Following a Suicide Attempt

CONSUMER PROTECTIONS UNDER FEDERAL INSURANCE LAW

By Dania Palanker,
Kevin Lucia and
JoAnn Volk

NAMI
National Alliance on Mental Illness

National Alliance on Mental Illness

About NAMI

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

About the Authors

Dania Palanker is an Assistant Research Professor and Kevin Lucia and JoAnn Volk are Research Professors at the Georgetown University McCourt School of Public Policy.

NAMI.org

NAMI HelpLine
800-950-NAMI (6264)

@NAMICommunicate
Facebook.com/NAMI
@NAMIcommunicate

NAMI
4301 Wilson Blvd., Suite 300
Arlington, VA 22203

Navigating Health Insurance Following a Suicide Attempt

CONSUMER PROTECTIONS UNDER FEDERAL INSURANCE LAW

The aftermath of a suicide attempt can be a challenging, confusing and painful time, both for the individual involved and their family. Some may be returning home from a hospitalization, trying to make sense of the situation, and hopefully moving forward on a journey of healing. In the best of times, health insurance can be difficult to understand. After surviving a life-threatening health crisis, deciphering health insurance bills can be overwhelming.

Thankfully, there are federal protections to ensure that most health insurance plans will pay for medical care resulting from a suicide attempt. However, there are many forms of health insurance and, unfortunately, some plans may expose people to substantial uncovered costs after an attempted suicide.

This report outlines existing federal legal protections and limitations for coverage of injuries related to a suicide attempt, as well as coverage gaps that may leave people vulnerable to unexpected medical bills.

Key Types of Commercial Health Insurance

Individual Plan

A health insurance plan purchased by you or your family directly (not through an employer)

Group Plan

Typically, a health plan offered by an employer or employee organization

ACA-Compliant Plans

Most individual and small group plans as well as other large group plans that meet Affordable Care Act (ACA) requirements

Non-ACA Compliant Plans

Individual or group plans that are exempt from many consumer protections and ACA requirements. Some common types include short-term limited duration plans (STLD) and health care sharing ministries

Who can help if I'm denied?

Don't forget to ask who regulates your insurance plan. Depending on your type of health plan, it may be regulated by your state insurance division, the U.S. Department of Labor or another entity. Regardless, you can usually get guidance from the consumer assistance department in your state insurance division.

- **Learn more about health plans at: https://content.naic.org/consumer/health-insurance.htm**
- **To find the consumer services contact for your state**, visit **https://www.naic.org/index_members.htm** and download the NAIC Insurance Department Directory
- **If you have an employer health plan,** call the federal Department of Labor at **1-866-444-3272**

1 Protections and Limitations Under Federal Law

HIPAA Non-Discrimination

The Health Insurance Protection and Accountability Act (HIPAA) is a federal law that provides protection against discrimination in eligibility, benefits and premiums in group health plans based on a person's health status. The Affordable Care Act (ACA) extends HIPAA protections to people enrolled in individual market plans.

An important provision of HIPAA's non-discrimination requirements is the source of injury protection. Under this provision, health insurance plans cannot deny benefits for treatment of an injury if:

- **The services are generally covered by the plan and**
- **The injury results from a medical (including mental health) condition.**[i]

Federal regulations make clear that the source of injury protection applies to injuries resulting from attempted suicide "if the injuries are the result of a medical condition (such as depression)."[ii] In addition, the regulations specifically note that the condition does not need to be diagnosed before the injury.[iii]

What does this mean practically?

Insurance plans covered by HIPAA (which does not include some plans, such as short-term limited duration [STLD] plans) must cover the costs associated with attempted suicide or other self-inflected injuries if a person has a health or mental health condition that is related to the attempted suicide or injuries. For example, if a person attempts suicide due to depression or schizophrenia, the health plan cannot deny payment for services that would otherwise be covered. This means that if emergency room services are typically covered by the plan, the plan cannot deny emergency room services for a self-inflicted injury. However, if the plan excludes certain services, such as physical therapy, then the plan can legally deny coverage for physical therapy to treat an injury.

A plan may incorrectly deny a claim if a diagnosed health or mental health condition that is associated with the injury is not reflected in the claim. A plan may also deny a claim if a person who attempted suicide does not currently have a related health or mental health diagnosis. However, a person may seek a diagnosis after the suicide attempt or self-inflicted injuries. If there is a diagnosis made, the claim may be resubmitted and become payable.

What can I do if I think my claim was denied based on lack of a related health condition?

If you believe your claim may have been denied due to lack of a diagnosed health or mental health condition associated with the suicide attempt or self-inflicted injuries, request that your provider resubmit your claim with a new or existing diagnosis or file an appeal. If a service was denied that is typically covered (and there is an associated health or mental health condition on the claim), file an appeal with your health plan and/or file a complaint with your state insurance division's consumer services office.

Find contact information at https://www.naic.org/index_members.htm (download the NAIC Insurance Department Directory)

Have a story?

If your plan denied coverage after a suicide attempt or you were met with surprise medical bills, share what happened at https://nami.quorum.us/campaign/share/. Your story will help us fight for needed consumer protections.

Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (federal parity law) requires most employer health insurance plans to provide mental health services **at parity** (at an equivalent level) with other medical services covered by the plan, ***if*** they provide mental health coverage.[iv] The federal parity law does not require these plans to cover mental health services generally. The Affordable Care Act (ACA) extends federal parity protections to individual and small group market plans that must cover mental health services (ACA-compliant plans).

What does this mean practically?

A plan that is subject to the federal parity law cannot charge more for mental health services or place greater limitations compared to most comparable health services, such as:

- Requiring higher cost-sharing (the share of costs you pay out-of-pocket, such as copays, coinsurance and deductibles) for a mental health outpatient visit than for a physician outpatient visit.
- Placing stricter limits on the number of mental health visits covered compared to the number of physician outpatient visits covered.

In addition, medical management policies, such as prior authorization (a requirement that the health plan approve services before they are delivered), treatment reviews and determinations of whether a service is "medically necessary" and meets accepted standards of medicine, cannot be more stringent than those imposed on other medical benefits. For example, requiring a treatment review after eight outpatient physician visits and after only three outpatient mental health visits.

Many medical services to stabilize or treat injuries resulting from a suicide attempt are physical health services and parity does not play a role. However, if a person receives mental health services following a suicide attempt, either in a hospital or as follow-up outpatient care, then these services should be covered at parity if they are covered by the plan.

What can I do if I think my plan violated parity requirements?

If you believe your plan may be in violation of the federal parity law, file an appeal with your health plan and/or file a complaint with your state insurance division's consumer services office.

Find contact information at https://www.naic.org/index_members.htm (download the NAIC Insurance Department Directory)

Appeal, Appeal.

If your plan denies coverage for a service you think should have been covered, file an appeal with your health plan. If your health plan still denies your claim, request an independent, external review.[v] Read more at https://www.healthcare.gov/appeal-insurance-company-decision/appeals/.

Essential Health Benefits

The Affordable Care Act (ACA) requires most individual and small group market plans to cover 10 categories of **essential health benefits** (EHB).[vi] Relatively comprehensive emergency and mental health services are required in every state. However, the EHB varies between states, as it is based on a state benchmark of services, and there are a small number of health plans grandfathered by the ACA that do not have to provide these benefits.[vii]

What does this mean practically?

Most individual or small group market plans are subject to the ACA's EHB requirements, which includes coverage of emergency and mental health services. In addition, those benefits must meet federal mental health parity requirements (see section on the **Mental Health Parity and Addiction Equity Act**). All non-grandfathered individual and employer plans, regardless of size, are also prohibited from placing dollar limits on essential health benefits, so a plan cannot, for example, cover only $10,000 in emergency services.

Large group health plans and self-insured plans are not required to provide the essential health benefits, so it is possible for these plans to exclude mental health or emergency services entirely or to exclude coverage of certain conditions (such as only covering serious mental illness).

What can I do if I think I should be covered?

If you believe your plan may be subject to essential health benefits (and the federal parity law), and you have been denied benefits you believe should be covered, file an appeal with your health plan and/or file a complaint with your state insurance division's consumer services office.

Find contact information at https://www.naic.org/index_members.htm (download the NAIC Insurance Department Directory)

If you or someone you love is in crisis, call or text "9-8-8" to reach the 988 Suicide & Crisis Lifeline or chat at 988lifeline.org.

2 Coverage Gaps

High Cost-Sharing

Health plans are permitted to impose **cost-sharing** requirements, such as coinsurance, copays and deductibles, on covered services.

In 2019, the average deductible for a person in an employer plan was $1,655.[viii] In individual health plans, deductibles are often much higher. In 2020, for example, "silver level" plans on the federal health insurance marketplace had an average $4,544 deductible and "bronze level" plans had an average $6,506 deductible.[ix]

Federal law limits maximum out-of-pocket costs for in-network services considered to be essential health benefits, which includes mental health and substance use care. In 2020, the maximum annual out-of-pocket was $8,150 for an individual and $16,300 for a family.[x, xi]

What is the difference between a copay, coinsurance and a deductible?

- **Copay**: A set amount you pay for a doctor visit, prescription or other service, such as $10 for a primary care visit.
- **Coinsurance**: The percentage of the cost you are required to pay, such as 20% of hospital care. This may be required in addition to a deductible or copay.
- **Deductible**: A set amount you pay for health services and prescriptions before your plan begins paying, such as a $500 deductible.

What does this mean practically?

An insurer does not have to pay a claim if a person has not yet met their deductible. This means that even when services are covered by a plan, a person may face thousands of dollars in medical bills if they are enrolled in a health plan with a high deductible. Furthermore, once the deductible is met, some plans have high copays, such as hundreds of dollars for an emergency room visit, or require a person to pay a high coinsurance amount, such as 30% of the bill.

What can I do if I am not protected from high cost-sharing?

There is no legal protection for high cost-sharing, except for the ACA's limit on out-of-pocket maximums for in-network providers. If you are subject to high cost-sharing and have medical bills, consider contacting your provider's billing department and requesting a discount and/or a payment plan. When and if you can switch health insurance plans, it might be worth researching if another health insurance plan is a better option for you.

Balance Bills

A person may receive **balance bills**, also known as **surprise medical bills**, for out-of-network care. Balance bills arise when a person receives care from an out-of-network provider and the provider bills the person for significant costs beyond what the insurer pays and beyond a plan's cost-sharing.

The Affordable Care Act (ACA) requires coverage of out-of-network emergency services for individual and small group marketplace plans, but it does not prohibit balance billing on those services.

Some states have stepped in to protect people from balance billing. However, not all states have enacted limits on this costly practice, and those that have may not apply the limits to all plans or providers.[xii] State protections do not apply to federally-regulated ERISA plans, or self-insured employer-sponsored plans that cover 61% of privately insured employees.

What does this mean practically?

If a person has received care from an out-of-network provider and is not covered under a plan subject to state-level balance billing protections, they may receive costly bills for the balance of costs not covered by their health plan, in addition to a plan's cost-sharing.

Balance bills often arise in emergency situations, such as a suicide attempt. The selection of an emergency provider may be outside a person's control because they are not conscious or are brought to an emergency room by an ambulance. Some emergency departments, for example, may be out-of-network. Some providers, such as anesthesiologists, who provide services at an in-network facility, may still be out-of-network and can balance bill the patient. An issue that has become more common is emergency rooms that are in-network using physicians that are out-of-network.

What can I do about a balance bill?

You can check with your state insurance division's consumer services office to see if your plan is subject to any limits on balance billing. You can often negotiate bills directly with your health care provider to lower the cost. In some instances, your health plan may also be able to assist in the negotiation with the health care provider. However, some providers will only agree to a payment plan without any discount.

Find contact information at https://www.naic.org/index_members.htm (download the NAIC Insurance Department Directory)

Non-ACA Compliant Policies

The non-discrimination and financial protections discussed previously apply only to what is generally considered comprehensive health insurance. However, there are many other **alternative coverage arrangements**, also referred to as "junk insurance," that do not have to comply with the ACA, HIPAA or the federal parity law.[xiii]

These health insurance products include short-term limited-duration health insurance plans, association health plans, fixed indemnity products and accident-only plans, among others, that are heavily marketed to consumers as a lower-cost health insurance option. In addition, health care sharing ministries do not need to comply with any of the federal protections.

In addition to marketing to individuals, fixed indemnity plans and other supplemental coverage may be offered by an employer to complement their health plan and reduce employee cost-sharing. However, the supplemental coverage may have limits and exclusions that do not exist in the primary health plan.

What does this mean practically?

Alternative coverage arrangements, or "junk insurance," can often specifically exclude services resulting from an attempted suicide or self-inflicted injury, regardless of medical diagnosis. Alternative coverage arrangements do not have to cover:

- Essential health benefits (such as emergency and mental health services and prescriptions).
- Preexisting conditions.

These forms of coverage may also place low dollar limits on covered services and they are not subject to the federal parity law.

People enrolled in alternative coverage arrangements can find themselves with little or no coverage for services resulting from a suicide attempt. A person enrolled in an employer plan who has purchased supplemental coverage may find the primary plan covers their claims, but the supplemental insurance does not, so they are left with unexpected cost-sharing.

What can I do if I have a non-ACA compliant policy?

Alternative coverage arrangements provide few protections and they do not need to comply with the Affordable Care Act's (ACA) requirement that allows for an independent external review of appeals when a claim is denied. When and if you can switch plans, consider a comprehensive health insurance plan with greater protections.

If you or someone you love is in crisis, call or text "9-8-8" to reach the 988 Suicide & Crisis Lifeline or chat at 988lifeline.org.

End Notes

i 45 CFR 146.121 prohibits discrimination based on "source of injury" in the group market; 45 CFR 147.110 extends those protections to the individual market.

ii Treas. Reg. Sec. 54.9802-1(b)(2)(iii), Example 1; DOL Reg. Sec. 2590.702 (b)(iii), Example 1; HHS Reg. Sec. 146. 121 (b)(2)(iii), Example 1.

iii Treas. Reg. Sec. 54.9802-1(b)(2)(iii); DOL Reg. Sec. 2590.702 (b)(iii); HHS Reg. Sec. 146. 121 (b)(2)(iii).

iv Treas. Reg. Sec. 54.9812-1; DOL Reg. Sec. 2590.712; HHS Reg. Sec. 146.136.

v Some alternative coverage plans, such as short-term limited duration plans and health care sharing ministries are not subject to independent, external review requirements.

vi HHS Reg. Sec. 156.115 details provision of the essential health benefits.

vii Grandfathered health plans are those that were in effect on March 23, 2010, and have not made substantial changes to plan costs and benefits since that date. Kaiser Family Foundation, "**2019 Employer Health Benefits Survey**" (Sep. 2019). To learn more about grandfathered plans, visit **https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/**.

viii Kaiser Family Foundation, "**2019 Employer Health Benefits Survey**" (Sep. 2019).

ix Kaiser Family Foundation, "**Cost-Sharing for Plans Offered in the Federal Marketplace**" 2014-2020" (Dec. 2019).

x HHH Reg. Sec. 156.130 details cost-sharing requirements related to the essential health benefits.

xi More information is available on ACA marketplace plans at **https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/**.

xii Jack Hoadley, Kevin Lucia and Maanasa Kona, "**States Are Taking New Steps to Protect Consumers from Balance Billing, But Federal Action is Necessary to Fill Gaps**," The Commonwealth Fund, Jul. 31, 2019.

xiii Kevin Lucia, *et. al.,* "**State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market**" The Commonwealth Fund (March 2018).