



A LONG ROAD Ahead ▶

Achieving True Parity
in Mental Health and
Substance Use Care



National Alliance on Mental Illness





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NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization. NAMI provides advocacy, education, support and public awareness so that all individuals and families affected by mental illness can build better lives.

Acknowledgements and Gratitude

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INTRODUCTION

A Long Road Ahead – Achieving True Parity in Mental Health and Substance Use Care

For too long, people who need mental health and substance use care have been subjected to pervasive discrimination in health insurance. Health plans for people with pre-existing mental illness, if they included mental health benefits at all, have historically been more expensive, with limited benefits and significant administrative hurdles to obtaining care.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) enacted by Congress in 2008, was designed to remedy a major piece of the problem.ⁱ This landmark law applies to employer-sponsored health plans with more than 50 employees, including self-insured and fully insured plans.ⁱⁱ MHPAEA does not require insurers to cover mental health and substance use treatment benefits, but if a plan includes these benefits, coverage must be on par with medical and surgical benefits.ⁱⁱⁱ

The Patient Protection and Affordable Care Act of 2010 (ACA) strengthened parity requirements set forth in MHPAEA by extending federal parity requirements to individual and small group plans. Further, mental health and substance use disorder services were mandated as one of ten categories of Essential Health Benefits required for all plans sold through the federal health insurance marketplace, or state exchanges.

These two important laws represent a monumental step forward in the long fight to end discriminatory coverage

of mental illness and substance use disorders in health insurance policies. However, it is well known that efforts to achieve meaningful social change are far from over when laws are passed. Achieving true equity in accessing mental health and substance use disorder care requires vigilant attention by advocates and public agencies responsible for enforcement.

This report describes a survey conducted by NAMI to assess the experiences of people living with mental illness and their families with private health insurance. The findings of the survey are supplemented with an analysis of 84 health plans in the top 15 states by projected 2014 exchange enrollment. Our findings reveal that while progress is being made in law, we have a long way to go to achieve true parity in mental health and substance use care.

The report describes a number of barriers that people with mental illness and substance use disorders encounter in their efforts to obtain quality care. Some of these barriers appear to be worse for mental health or substance use treatment, while others apply equally to medical care. These barriers include:

- Serious problems in finding mental health providers in health insurance plan networks;
- High rates of denials of authorization for mental health and substance use care by insurers;

- Barriers to accessing psychiatric medications in health plans;
- High out of pocket costs for prescription drugs that appear to deter participation in both mental health and medical treatment;
- High co-pays, deductibles and co-insurance rates that impose barriers to mental health treatment;
- Serious deficiencies in access to information necessary to enable consumers to make informed decisions about the health plans that are best for them in ACA networks.

Although people living with mental illness and substance use disorders are grateful for the steps Congress and the Administration have taken to increase fairness through MHPAEA and the ACA, the problems described in this report must be addressed for the great promise of these landmark laws to translate into improved access to quality care.

REPORT FINDINGS

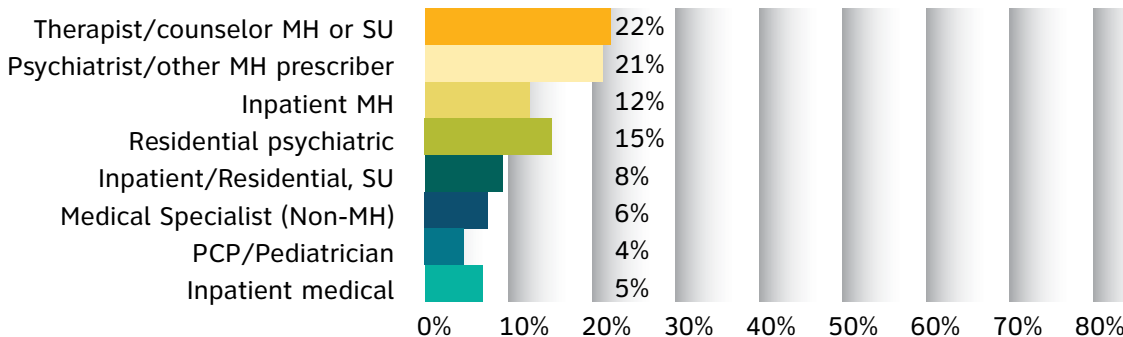
1. Consumers and family members report serious problems with finding mental health providers in their health plans.

Whether health insurance is obtained through employment or purchased by individuals through health insurance marketplaces, a significant percentage of respondents to our survey reported problems in finding mental health providers in their health plans. The most significant problem identified was difficulty accessing therapists or counselors for outpatient mental health or substance use disorder treatment, followed closely by difficulties accessing psychiatrists. Respondents also reported higher rates of difficulty accessing inpatient psychiatric or residential treatment than they did for accessing medical specialty services, primary care services, or inpatient medical

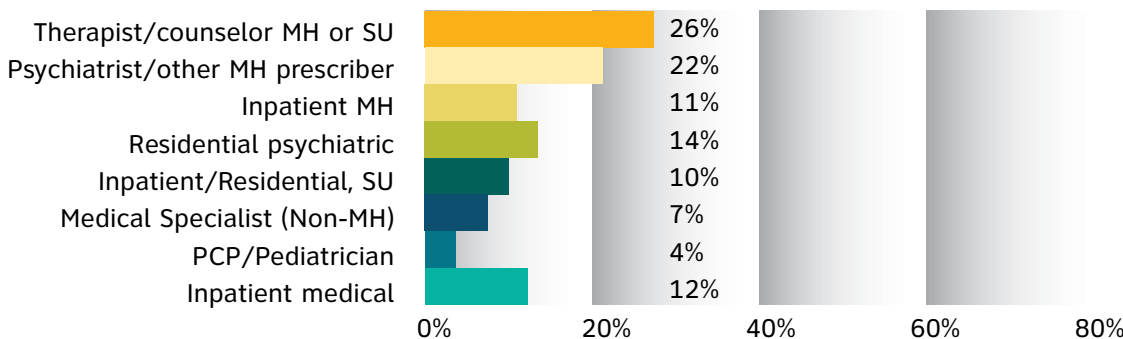
“Our rural county has incredible lack of compassionate, effective resources for mental health and substance abuse. My son is on an injectable medication. It was very difficult to find a provider who would administer the medication. The insurance company did find a provider, but he is not in-network.”

treatment. Consumers clearly face more significant barriers to accessing inpatient and outpatient psychiatric or mental health care than they do in accessing inpatient or outpatient medical specialty or primary care.

Cannot find a provider in the plan’s network: all private insurance



Cannot find a provider in the plan’s network: ACA only



Most likely, these barriers are attributable both to severe shortages in qualified mental health professionals in most parts of the country and to inadequate provider networks maintained by health insurance plans. The nationwide mental health workforce shortage is well documented, and these problems are particularly acute in rural regions. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 55% of U.S. Counties have no practicing psychiatrists, psychologists or social workers.^{iv}

Making matters worse, concerns have emerged that a significant number of mental health professionals included in networks of Qualified Health Plans (QHPs) included in health insurance exchanges may not actually be available to plan participants. For example, in January, 2015, the Mental Health Association of Maryland published a study which revealed that only 14% of the psychiatrists listed in QHPs in the Maryland exchange were actually accepting new patients and available for an appointment within 45 days.^v

“My insurance will pay my primary care doctor more for a 10-minute appointment for the flu, than it will allow my psychiatrist for an hour-long treatment session. For this reason, my own psychiatrist along with many others, no longer accepts insurance.”

Compounding the problem of mental health workforce shortages is the reality that many practicing psychiatrists do not accept health insurance, confining their clientele to people with the resources to pay out of pocket. A recent study published in JAMA Psychiatry revealed that only 55% of psychiatrists accepted insurance in 2009-2010 as compared

to 88.7% among physicians in other medical specialties. The data further revealed significantly lower Medicare and Medicaid acceptance rates among psychiatrists than physicians in other medical specialties.^{vi}

A number of reasons are cited for the distressingly low rates of psychiatrists accepting insurance, including lower payment rates for psychiatrists (although the study cited above reveals comparable payments for psychiatrists and other medical specialties), the longer duration of therapy sessions versus medical appointments and the burden of documentation requirements for solo practitioners.^{vii}

The difficulties respondents reported accessing mental health therapists and counselors is more surprising. Psychologists, social workers and mental health counselors provide vital psychotherapy and counseling to people with mental illness and/or substance use disorders. The finding that so many respondents had trouble obtaining a therapist who would take their health plan, suggests that these individuals, despite having insurance, may have little or no access to needed services and supports.

A recent report issued by the Commonwealth Fund revealed that premiums on average are significantly lower for people purchasing health insurance through the Marketplaces than originally anticipated. A primary reason for this is that beneficiaries are selecting lower cost plans that also have far more limited provider networks.^{viii}

Whatever the reason for the reported difficulties in accessing providers, the goals of mental health and substance use parity will be frustrated

by insufficient access to providers qualified and willing to serve people with mental illness or substance use disorders. In fact, problems with access to services may be exacerbated as demand increases due to more people having insurance through the ACA.^{ix}

2. Insurers are denying authorization for mental health care at higher levels than they are for other types of medical care.

The parity requirements in MHPAEA apply to both Quantifiable Treatment Limits (QTLs), such as cost sharing, visit limits, or deductibles, and to Non-Quantifiable Treatment Limits (NQTLs), such as medical necessity criteria used by insurance companies and managed care organizations to approve or deny care. “Medical necessity” is a managed care tool intended to evaluate whether care proposed by a provider for a given patient is reasonable, necessary and appropriate, based on evidence-based clinical standards of care. Consumers, family members and providers often complain that mental health or substance use treatment is denied as not medically necessary arbitrarily and without reasonable explanation.^x

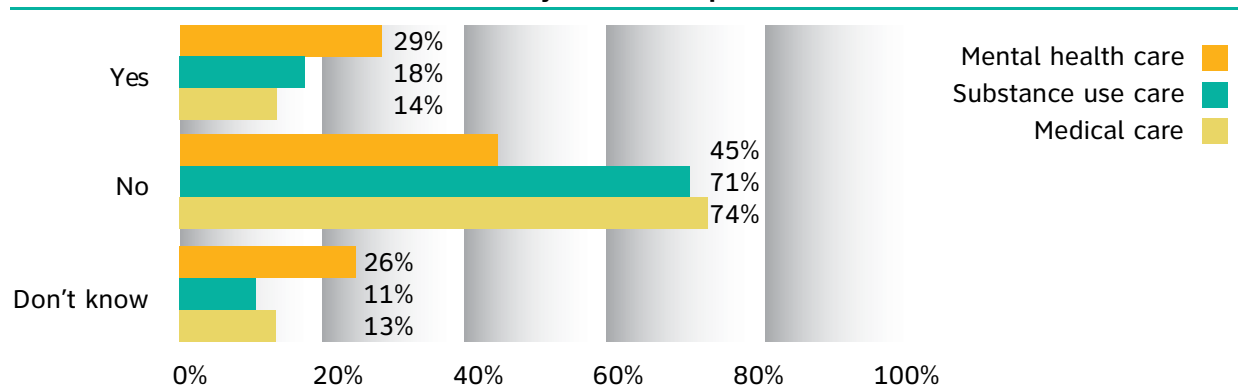
NAMI asked respondents whether their health plan has denied mental health, substance use and/or medical services recommended by their clinician because they were deemed

“Our health insurance denied all claims for one year retroactively, asking all of my and then all of my husband’s providers to refund monies paid, putting my health, my psychiatric health, and my husband’s health at risk.”

“not medically necessary.” Because of MHPAEA’s application to NQTLs such as medical necessity, the reasonable expectation is that reported denials of care for mental health, substance use, and medical care would be roughly equal.

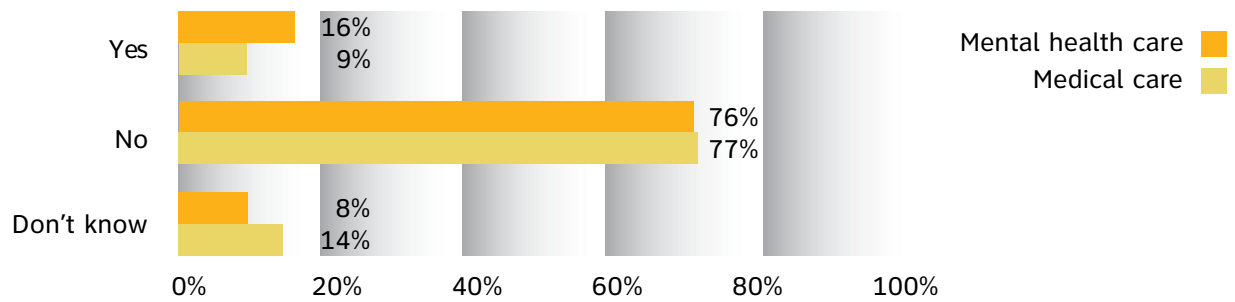
However, nearly one third (29%) of respondents reported that they or their family member had been denied mental health care on the basis of medical necessity, more than twice the percentage who reported being denied general medical care. 18% of respondents reported being denied substance use care and 14% denied general medical care. For ACA plans, rates of reported denials based on medical necessity were lower, but denials for mental health care were still nearly twice the rate of denials for general medical care.¹

Service denials based on medical necessity criteria: all private insurance



¹ Only four of the ACA respondents reported seeking substance use care. This was too few to accurately compare responses with other types of care.

Service denials based on medical necessity criteria: ACA only



Historically, there has been lack of clarity about the medical necessity criteria used by insurance companies and managed care organizations for mental health and substance use disorder care.^{xi} In the absence of uniform criteria, insurers have adopted their own standards and have often not been forthcoming about informing beneficiaries about these standards.^{xii} This in turn has sparked concerns that insurance companies and managed care organizations deny claims for mental health care at far higher rates than for other medical care. The results obtained in our survey would appear to reinforce these concerns.

In fact, as this report was being finalized, news broke that Beacon Health Options of New York has agreed to change the way it handles mental health and drug and alcohol claims and will be fined \$900,000. The settlement resolved allegations that the company denies mental health claims at twice the rate it does for

medical/surgical claims and denies drug and alcohol claims at 4 times the rate.^{xiii} Other media stories have also portrayed exceedingly high rates of claims denials for mental health care.^{xiv}

The common use of medical necessity criteria and other utilization management tools to limit care for mental illness is particularly concerning because it is very difficult, if not impossible for consumers and family members to find information on the criteria used to make such decisions. Health insurance policies typically do not include information about medical necessity criteria regarding specific types of care.

This lack of transparency exists as well for summary documents used to provide information about specific plans included in state health insurance marketplaces under the ACA. Without transparent, easily available information, the ability of mental health consumers to make informed choices about plans - or to assert their rights in the face of adverse decisions - is severely hamstrung.

“Our health plan for medical is great. Their behavioral health arm for prescriptions is not great. They have an appeal process but they never even respond to your appeal and even if the doctor shows that the generic didn’t work, they still won’t approve branded. Luckily, we can pay out of pocket for the medication, but we, his parents, pay for our 20 year old’s medication. He could never afford it. Thank God for the Affordable Care Act; at least he is covered on parent’s insurance until age 26.”

3. There appear to be significant barriers to accessing psychiatric medications in health insurance plans.

Insurance plans generally cover prescription drugs on a tiered basis. Tier one medications are most easily available and most affordable. Higher tier medications are more expensive and are frequently not available except through specific requests for exceptions or authorizations.

The imposition of specific limitations on psychiatric medications is particularly problematic because these medications are frequently not interchangeable. The National Institute of Mental Health (NIMH) explains that psychiatric “medications work differently for different people.” Factors affecting variability include diagnosis; age, sex and body size; genetics; physical illness; diet and others. “Some people get side effects from specific medications, others don’t.”^{xv}

In view of this, decisions about psychiatric medications must be made carefully between the treating clinician and his or her patient. The effectiveness and side effects of the prescribed medication must be carefully monitored. Restrictions imposed by insurance companies through tiered formularies can deprive individuals of these safeguards and upset the often delicate balance of a psychiatric medication regimen.

NAMI contracted with Avalere Health to conduct a review of drug formularies in plans provided through health insurance marketplaces in selected states. Formularies for 84 health plans were analyzed to assess coverage of three

classes of psychiatric medications, Antipsychotics, Antidepressants, and SSRIs/SNRIs (selective serotonin reuptake inhibitors [SSRI] and selective norepinephrine reuptake inhibitors [SNRI]) used commonly to treat depression.

The results were troubling, particularly for coverage of antipsychotic medications used in the treatment of schizophrenia and other disorders characterized by psychosis.

For antipsychotics, more than half of the health plans (47) covered fewer than 50% of analyzed drugs, meaning that the majority of antipsychotic medications weren’t available to plan participants at all.^{xvi} Additionally, although a number of plans covered a higher percentage of anti-psychotic medications, a significant proportion of these medications were available only on a restricted, non-preferred basis with high out of pocket costs. For example, a third (28 health plans) placed at least half of covered antipsychotic medications on Tier 3 of the drug formularies, meaning that these drugs could not be prescribed without being subject to higher cost sharing than generic or ‘preferred’ branded products.

Coverage of antidepressants was somewhat better, with 22 plans covering at least 70% of these medications. Over half (46 health plans) placed at least 50% of these medications on Tier 1 preferred status. Even so, a number of plans placed a significant number of covered drugs on higher cost tiers, with 13 plans placing at least half of the covered antidepressants on Tier 3 and 11 plans placing more than 20% of antidepressants on Tier 4.

More than a quarter (22 plans) covered at least 70% of SSRIs and SNRIs. Nearly half (42 health plans) placed at least 50% of these drugs on Tier 1, while 16 plans placed at least half on Tier 3, and 13 plans placed more than 20% on Tier 4.

There were variations across states as well. In Arkansas, three of the four assessed plans covered fewer than 65% of medications in each class. By contrast, in New Jersey, three of four plans covered 100% of the drugs in each class.

There were broad variations in coverage among specific companies administering these plans. Nearly two thirds (48) of the plans were considered “more restrictive” for at least one class of drug, 21 plans were considered more restrictive for at least two of the three analyzed classes, and 12 plans were considered more restrictive for all three classes. Two companies in particular stood out for the restrictiveness of their plans. Nine of eleven Anthem plans included in the analysis were more restrictive for antidepressants and antipsychotics, the other two Anthem plans were more restrictive for all three classes. Further, all seven Humana plans included in the analysis were more restrictive in all three classes.

Do the restrictions described above constitute a violation of the federal MHPAEA law? As described earlier in this report, this law applies to all ACA plans offered through state health insurance marketplaces. If an ACA plan covers psychiatric medications at levels lower than medications for other health conditions, this may constitute a violation of MHPAEA. However, we do not have sufficient information to so conclude at this point.

In a more positive vein, 12 of the analyzed plans covered 100% of all drugs included in the three classes

4. Even when covered, the out of pocket costs of medications may pose a barrier to participating in care.

NAMI’s survey asked respondents whether their health plan covered the cost of medications fully or partly. For those with private coverage, medications for mental health care

Criteria for Identifying Restrictive Plans

Antidepressants and SNRIs/SSRIs	Antipsychotics
<ol style="list-style-type: none"> Plan covered 33% or fewer of analyzed drugs within the class. At least 70% of analyzed drugs within the class were not covered, or placed on Tier 3 or Tier 4. At least 70% of analyzed drugs within the class were not covered, or required Prior Authorization, Step Therapy, or both Prior Authorization and Step Therapy. 	<ol style="list-style-type: none"> Plan covered fewer than 30% of analyzed drugs within the class. At least 90% of analyzed drugs within the class were not covered, or placed on Tier 3 or Tier 4. At least 90% of analyzed drugs within the class were not covered, or required Prior Authorization, Step Therapy, or both Prior Authorization and Step Therapy.

analyzed. None of the four Aetna plans or the two Cigna plans were assessed as having more restrictive coverage.

were slightly more likely to be covered fully (10%) or partly (87%), when compared with medications for

“Once I aged out of my parents’ plan (which was very good coverage) the cost of my medications tripled. I could no longer get a three-month supply for meds I had been on for years, only a one-month supply. I chose the plan because of the low advertised cost of prescriptions, but they have yet to be those prices. Increased cost was the reason I stopped all four of my psychiatric medications within two months of each other.”

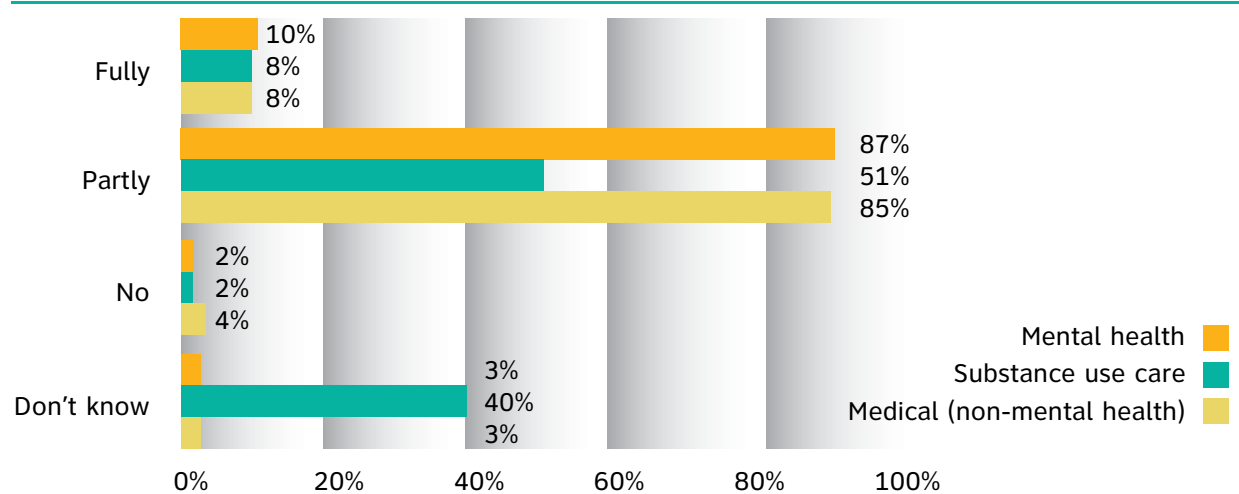
medical care (fully, 8%; partly 85%). Participants were less likely to know about substance use medications, though full cost coverage lagged slightly behind mental health (8%) and partial coverage was far lower (51%).

Medication cost coverage under ACA plans was similar with medications for mental health care slightly more likely to be covered fully (12%) or partly (88%) when compared with medications for other types of medical care (fully, 11%; partly 83%).

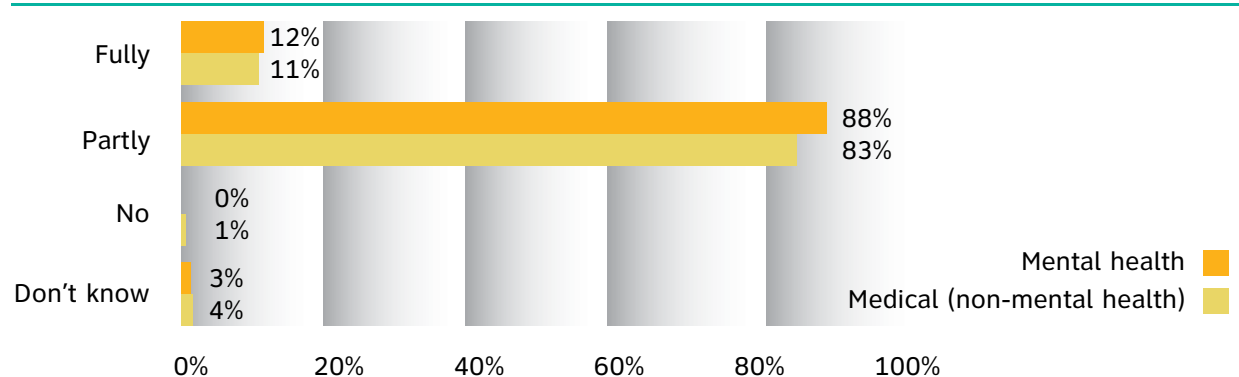
However, partial coverage of medications can result in significant out of pocket costs for beneficiaries, costs that are sometimes so high that people choose to forego needed prescription drugs. This proved to be the case for a number of respondents to our survey.

When asked whether, due to cost, they had been unable to fill a prescription for mental health, substance use, or medical care, 17 percent of respondents reported that they were unable to fill prescriptions for mental health care, 30 percent

Coverage of medication costs: all private insurance



Coverage of medication costs: ACA only



reported that they were unable to fill prescriptions for substance use disorder care and 33 percent reported that they were unable to fill prescriptions for other medical care.

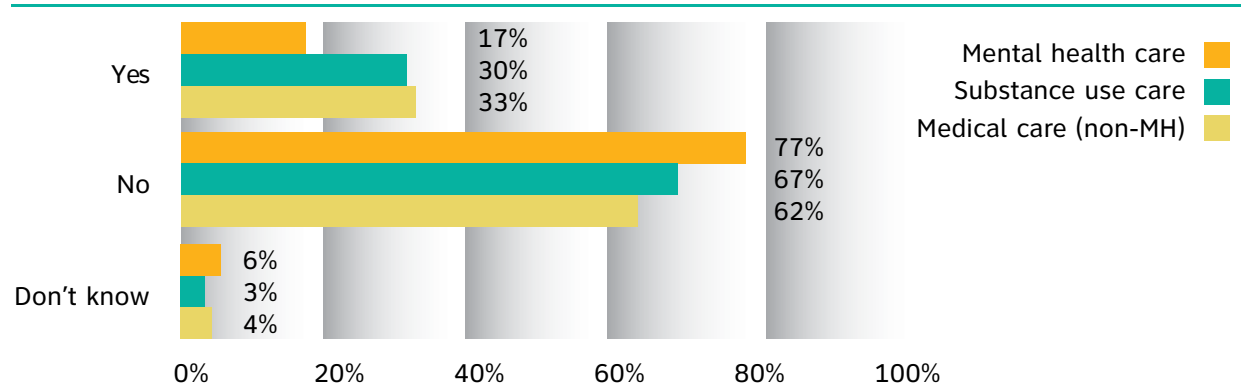
These percentages were even higher with ACA marketplace plans than for insurance plans in general (mental health 32%; general medical 33%). Since the income profiles of respondents in both groups were similar, this suggests that out of pocket costs for prescription drugs are higher in ACA plans than other types of insurance plans.

Co-insurance requirements in health plans can be particularly problematic for consumers. Co-insurance requires beneficiaries to pay a fixed percentage of the costs of the service or medication. Medications on higher tiers in ACA plans are often subject to co-insurance as opposed to a flat fee, or copayment. Consumers who purchased ACA plans may not have been aware of the difference between these two practices, which can mean widely varied out of pocket costs. When the cost of a prescription drug is \$900 per month, as is the case

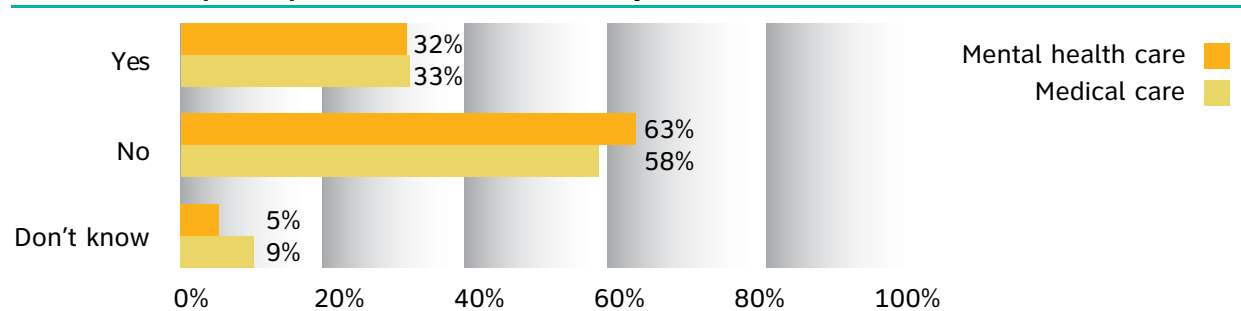
with some antipsychotic medications, a 40% co-insurance requirement requires the person to pay \$360 per month out of pocket. Such costs are unsustainable for many consumers and thus may serve as a major barrier to taking needed psychiatric or other types of medications.

5. Out of pocket costs may present a greater barrier to inpatient and outpatient mental health care than inpatient or outpatient medical specialty care.

Not able to fill prescription due to costs: all private insurance



Not able to fill prescription due to costs: ACA only

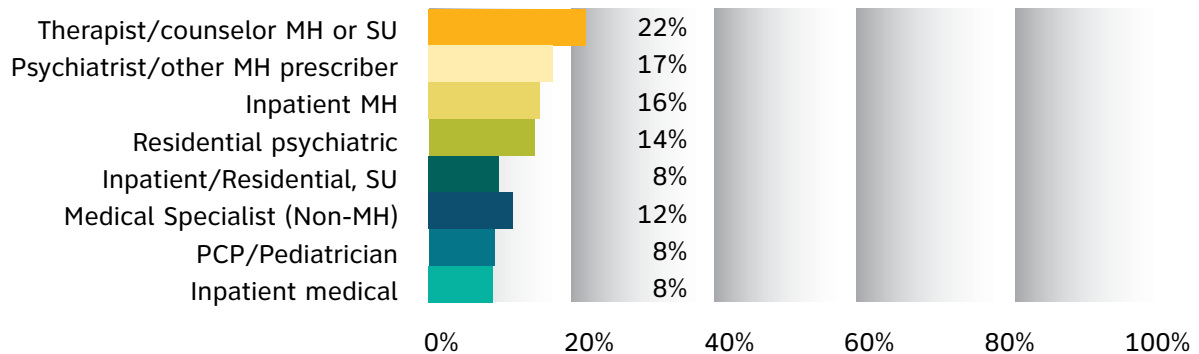


“My income per month is \$860. My co-pays for medical and mental health are often \$120-\$160. If I cancel mental health appointments because I am broke, the therapist or psychiatrist notes state that I am non-compliant. I pay \$120 to \$180 on past hospital stays, which had fees before I met my deductible. I pay \$400 a month to rent a room. I choose to stay on my meds so I skimp on nutrition.”

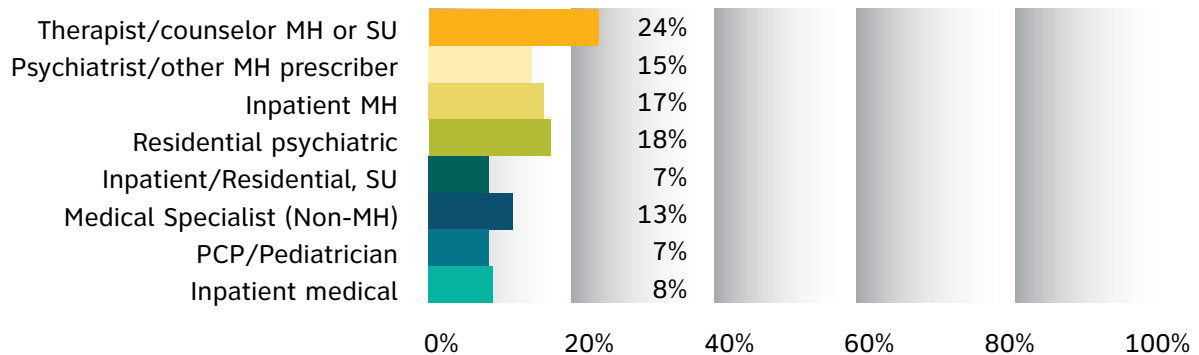
More respondents cited out of pocket costs (deductibles, co-pays, coinsurance) as barriers to seeking inpatient or outpatient mental health care than for primary care or inpatient or outpatient medical specialty care. This was true as well for ACA plans. More information is needed to determine whether these differences reflect higher out of pocket costs for inpatient and outpatient mental health care than for other types of medical care, which could constitute non-compliance with the federal parity law.

Also noteworthy is that many of our survey respondents reported having to pay sizable deductibles in their health insurance policies. These deductibles apply to the costs of all care, whether mental health, substance use, or medical care. Although deductibles in ACA plans did not exceed \$10,000 as was the case with a few non-ACA plans, 20% of the ACA plans carried deductibles from \$2,500 to \$5,000, while 22% had deductibles between \$5,000 and \$10,000. Out of pocket costs of this magnitude may deter people from participating in needed care.

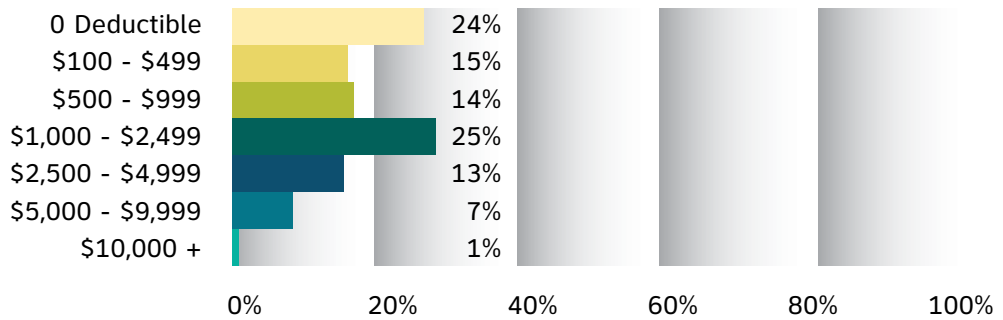
Cost as barrier to care: all private insurance



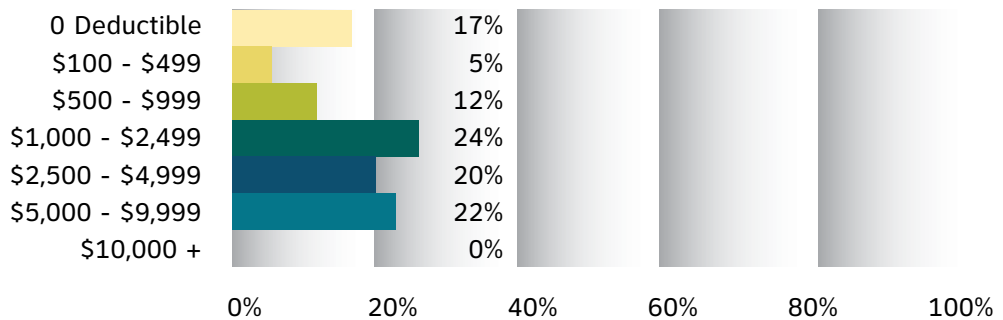
Cost as barrier to care: ACA only



Annual deductible: all private insurance



Annual deductible: ACA only



6. When selecting health plans available in State Marketplaces, consumers and family members generally do not have access to information needed to make informed decisions.

The ACA requires each Marketplace plan to publish a Summary of Benefits and Coverage (SBC) with cost sharing

and coverage information. These documents do not include the kind of detailed information about coverage that mental health consumers need to make informed decisions about the plans that are best for them. For example, these documents typically do not include information about provider networks, meaning that a consumer would be unable to determine if his or her psychiatrist is part of the network.^{xvii} Additionally, even when provider information is available, for example through the shopping function in Healthcare.gov, the provider directories provided by plans are often inaccurate and outdated.

More detailed information about provider networks, out of pocket

"It is impossible to figure out the best way to get coverage for the services I know I need. It's always a crapshoot, and the people at the state exchange are too busy signing people up to help me figure out how to get the subsidy that I think I am entitled to. But the rules are so complicated and have so many exceptions. The ACA is a better solution than the system we had before, but it is still too hard to afford, too complicated, and people are still going to fall through the cracks."

costs, and specific services covered may be found in documents known as Evidence of Coverage (EOC) or Certificates of Coverage. However, these documents are frequently not publicly available. The Avalere analysis of 84 plans revealed that these more detailed plan documents were publicly available for only 15 of the 84 plans analyzed.^{xviii} Eight of the 15 plans for which detailed documents were available were in California, which has a state law requiring the publication of detailed documents about plans.”^{xix}

Even when more detailed documents are available, they are generally quite complicated and may not contain the level of detail required. As noted by

Avalere, the more detailed documents are written in different formats and with varying levels of detail. For example, some “plan documents contained broad statements (e.g. ‘prior authorization may be required, or services not covered’) without additional information.”^{xx}

The lack of specificity in Summary of Benefits and Evidence of Coverage documents is problematic not only for consumers trying to make informed choices about plans that are best for them. Lack of specificity in these documents also inhibits conducting a detailed assessment of whether plans are complying with requirements of the federal parity law.

A recent study conducted by researchers at Johns Hopkins University illustrates this difficulty. The researchers analyzed plan offerings on the health insurance marketplaces in two states. When trying to assess parity in non-quantitative treatment limits, they observed that, “summary documents do not provide information on how medical management protocols (for example, provider network admission standards, fee schedules, step therapy protocols and medical necessity determinations) are applied to covered benefits.”^{xxi}

POLICY RECOMMENDATIONS

1. Strong enforcement of MHPAEA is needed.

The enforcement scheme for MHPAEA is complicated. States have primary authority over implementation. However, the U.S. Department of Labor has primary enforcement responsibility for self-insured employee plans (the majority of employees in plans subject to MHPAEA). Further, the U.S. Department of Health and Human Services, through its Center for Medicare and Medicaid Services (CMS) has enforcement authority when states fail to exercise this authority.^{xxii}

A complex, multi-faceted enforcement scheme of this kind creates confusion, both among consumers and agencies responsible for enforcement. Federal and state agencies responsible for enforcement should work with consumer and family organizations and other stakeholders to develop an easily accessible mechanism to report incidents of non-compliance with the federal parity law. The two agencies with federal oversight must establish a procedure for monitoring these reports for patterns of non-compliance and develop procedures to help ensure enforcement.

2. Insurers should be required to publish the clinical criteria they use to approve or deny care.

Respondents to our survey revealed that insurers deny authorization for mental health care at higher levels than they do for other medical care. It is difficult to prove that disparate levels of denials for mental health care relative to other medical care violate MHPAEA. To do so requires comparisons of the clinical protocols used by insurers for mental health

care with those used for medical-surgical care. It also requires assessment of whether insurers are accurately applying these clinical protocols to decisions in individual cases.

It is currently very difficult to access clinical protocols such as medical necessity criteria for purposes of review and comparison. HHS should require all plans participating in health insurance exchanges to publish these clinical protocols in publicly accessible sites such as HealthCare.gov and exchange websites established by states. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA), in consultation with the National Institute of Mental Health (NIMH), the Assistant Secretary for Planning and Evaluation (ASPE) and other relevant HHS agencies, should promulgate guidance to health plans on appropriate clinical criteria for insurers to use in approving or denying mental health and substance use care.

3. Health plans should be required to publish accurate lists of providers, including mental health providers, participating in plan networks and to update those lists regularly.

Narrow, limited provider networks have been identified nationally as a problem in health insurance exchanges and our survey revealed that this is a problem for mental health care in all types of insurance plans, whether employer based or through the ACA. In recognition of this, the final rule published by CMS establishing Benefit and Payment Parameters for 2016 requires Qualified Health Plans participating in health

insurance marketplaces to publish up-to-date, accurate and complete plan specific provider directories, including information on which providers are accepting new patients.^{xxiii}

The National Association of Insurance Commissioners (NAIC) is currently drafting model state network adequacy legislation. This model legislation should include similar requirements as the federal Benefit and Payment Parameters for 2016, with specific focus on ensuring adequacy for specialties that have been historically under-represented in health insurance networks, such as psychiatrists, psychologists and other mental health professionals. NAIC model legislation is not binding on states but frequently serves as a model for state laws.

4. HHS should require all health plans to provide clear and understandable information about benefits and should be required to make this information easily accessible.

Health plans should be required to provide sufficiently detailed information in easily understandable language to enable consumers and advocates to compare health and mental health benefits in plans offered through state and federally-facilitated health insurance exchanges. Detailed plan documents should include all information necessary for consumers and advocates to make informed decisions about the best coverage to purchase. At a minimum, information disclosed should include the following:

- an accurate up-to-date provider network listing;
- quantifiable limits on coverage including inpatient and outpatient treatment;

- medical necessity criteria or other utilization review practices;
- prescription drug formularies and the policies for approval;
- information to calculate out-of-pocket costs; and
- types of mental health and substance use benefits covered.

Health plan information should be accessible to consumers before enrollment, through health plan websites or by telephone. Finally, HHS should develop a uniform system for health plans to report this information to consumers and advocates and make it easy to find.

5. Congress and the Administration must work together to decrease out of pocket costs in the ACA for low income consumers.

Out of pocket costs include deductibles, copayments, and co-insurance for covered services. They do not include the costs of insurance premiums. Although individuals or families with incomes below 250% of the Federal Poverty Level^{xxiv} who purchase Silver Plans are eligible for subsidies to defray out of pocket costs, these costs can still be very high.^{xxv} Many respondents to our survey reported very high out of pocket costs, so high that they or their family member sometimes chose to forego needed mental health or medical-surgical care. As implementation of the ACA moves forward, careful consideration must be given to lowering out of pocket limits, particularly for low income individuals. Otherwise, the goal of increasing access to care, including mental health and substance use care may be frustrated.



APPENDIX 1:

Methodology and Coverage for Care Survey

Sample Characteristics

Information for this report derives from two primary sources, a NAMI survey on the experience of health coverage and an analysis of Health Insurance Marketplace and State Exchange Plan benefits performed by Avalere Health under contract with NAMI.

NAMI Coverage for Care Survey

In September and October of 2014, NAMI released a nationwide online survey of individuals and families of adults or children in need of mental health and/or substance use care. The survey inquired about access to, and out of pocket costs for, services and medications to treat general medical, medical specialty (non-mental health), mental health or substance use conditions. Eligible respondents could have any type of private or public health coverage including insurance obtained through health insurance marketplaces established under the Affordable Care Act (ACA).

Avalere Health Analysis

Analysis of formularies offered in the Qualified Health Plans relied on the Avalere Health proprietary PlanScape database and examined formulary coverage of mental health drugs by 84 selected Marketplace plans offered in 15 states. Avalere also performed a review of Summary of Benefits and Coverage (SBC) and Evidence of Coverage (EOC) documents to compare coverage of mental and physical health benefits.

Coverage for Care Survey Respondents

The 2,720 respondents were individuals and family members of adults or children who need mental

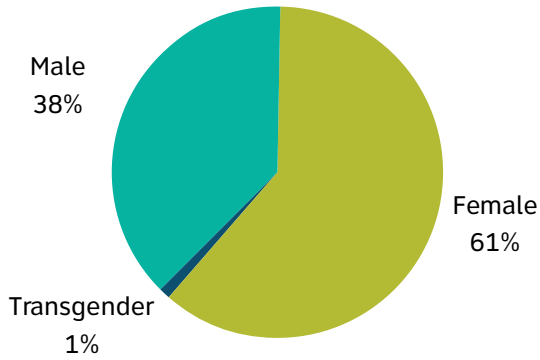
health or substance use care. Of those who started the survey, 70% followed through to completion. Nearly half (48%) answered for themselves, while 40% answered for a child, including adult children, and less than 5% answered for someone else. Persons who were the subject of responses were typically female, white, non-elderly adults with annual incomes below \$25,000. Every state was represented, though most lived in California (577), Colorado (105), Florida (194), Massachusetts (102), Michigan (98), Oregon (105) and Tennessee (108).

A majority of the survey sample (90%) had health coverage, either through private insurance or public programs. The higher than normal overall insured rate, compared to the average insured rate among people with mental illness (76%),^{xxvi} is likely because the survey invited respondents to describe their experience of health coverage, rather than enrollment. Mental health and substance use benefits were covered for 2,059 (88%) of the survey population. Almost all children and elderly adults were insured (98%) as were most young adults (90%) and other adults (88%).

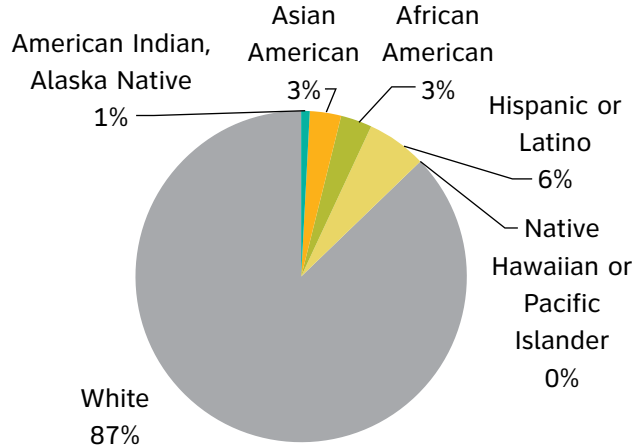
Respondents with private insurance coverage (1,225, 45%) are the subject of this report because the final parity rule for private insurance took effect July 1, 2014. Small percentages of the survey sample had Medicaid (5%) or Medicare (10%) in addition to their employer sponsored or individual plan. 220 respondents obtained coverage under the ACA, either through a Qualified Health Plan (121, 4%) or Medicaid expansion (99, 4%).

Demographic Characteristics

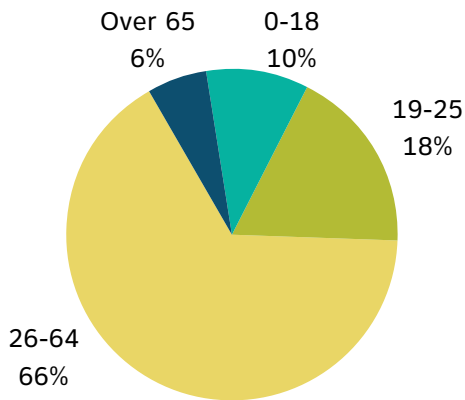
Gender



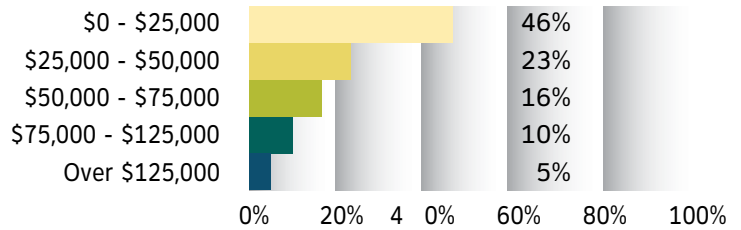
Race/Ethnicity



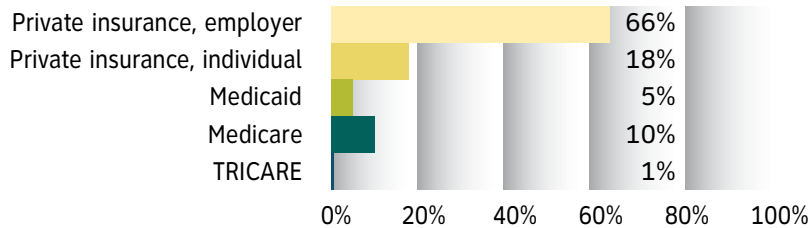
Age



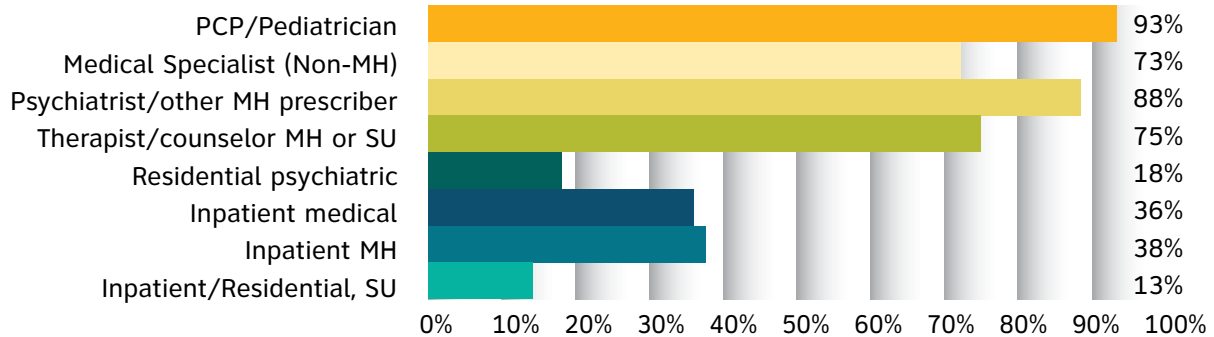
Annual Income



Type of Health Coverage



Type of Services Used



APPENDIX 2:

How do Parity Laws Apply to Types of Health Plans?

Two recently enacted federal laws strengthen health insurance coverage for mental health and substance use disorder (MH/SUD) services with the intention of making care more available to those who need it.

- **The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008** does not require insurers to provide MH/SUD benefits. However, if such benefits are provided, the financial requirements and treatment limitations for MH/SUD benefits must be equal to medical and surgical care.

- **The Patient Protection and Affordable Care Act (ACA)** extends parity by requiring some health plans to provide ten categories of Essential Health Benefits (EHB). Under the ACA, MH/SUD benefits *must* be provided through certain types of plans *in compliance with* MHPAEA.

While these policies represent an important step forward, gaps remain. The chart below shows which types of health plans are subject to parity requirements under MHPAEA and the ACA.

Exchange Plans	Type of Plan		Subject to parity under MHPAEA	Subject to parity under ACA: Essential Health Benefits*
		Individual		No
	Small group		No	Yes
Non-Exchange Plans	New Plans	Self-insured	Yes**	No
		Large group	Yes**	No
		Small group	No	Yes
		Individual	No	Yes
		Government plans: Non-Federal Small or self-funded++	No	No
	Grandfathered Plans+	Self-insured	Yes**	No
		Large group	Yes**	No
		Small group	No	No
		Individual	No	No
		Government plans: Non-federal Small or self-funded++	No	No

* Patient Protection and Affordable Care Act, Section 1302 (a) and (b): <http://www.hhs.gov/healthcare/rights/law/index.html>

** MHPAEA applies to employer-sponsored health plans with more than 50 employees, including self-insured and fully insured plans: <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>

+ MHPAEA does not apply to *non-federal governmental plans* that have 100 or fewer employees or large self-funded non-federal governmental plans that choose to opt out of MHPAEA: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

++ Grandfathered plans are those that were purchased before March 2010 and remain largely unchanged.

APPENDIX 3:

Population of Marketplace-Eligible People with Mental Illness

State	Total Marketplace eligible population ²	% Marketplace eligible with any mental illness (AMI) ³	# Marketplace eligible with AMI
Alabama	463,000	19.2%	88,896
Alaska	84,000	17.4%	14,616
Arizona	647,000	18.4%	119,048
Arkansas	251,000	21.0%	52,710
California	3,263,000	11.0%	358,930
Colorado	574,000	13.5%	77,490
Connecticut	236,000	11.1%	26,196
Delaware	45,000	7.6%	3,420
District of Columbia	32,000	10.1%	3,232
Florida	2,502,000	10.6%	265,212
Georgia	1,073,000	4.9%	52,577
Hawaii	53,000	20.0%	10,600
Idaho	229,000	21.6%	49,464
Illinois	966,000	14.6%	141,036
Indiana	673,000	15.9%	107,007
Iowa	224,000	11.3%	25,312
Kansas	244,000	15.0%	36,600
Kentucky	265,000	12.7%	33,655
Louisiana	506,000	16.7%	84,502
Maine	124,000	11.2%	13,888
Maryland	462,000	6.4%	29,568
Massachusetts	400,000	16.2%	64,800
Michigan	699,000	14.8%	103,452
Minnesota	277,000	15.6%	43,212
Mississippi	293,000	16.6%	48,638
Missouri	632,000	13.4%	84,688
Montana	125,000	16.5%	20,625
Nebraska	237,000	20.1%	47,637
Nevada	266,000	13.5%	35,910
New Hampshire	129,000	13.9%	17,931
New Jersey	586,000	15.7%	92,002
New Mexico	153,000	6.1%	9,333
New York	1,214,000	10.0%	121,400
North Carolina	1,098,000	11.8%	129,564
North Dakota	80,000	18.8%	15,040
Ohio	962,000	15.1%	145,262
Oklahoma	381,000	20.8%	79,248
Oregon	339,000	13.8%	46,782
Pennsylvania	1,171,000	13.7%	160,427
Rhode Island	73,000	28.7%	20,951
South Carolina	444,000	15.1%	67,044
South Dakota	100,000	13.4%	13,400
Tennessee	602,000	14.6%	87,892
Texas	3,079,000	13.3%	409,507
Utah	385,000	15.4%	59,290
Vermont	44,000	22.2%	9,768
Virginia	816,000	20.9%	170,544
Washington	517,000	14.1%	72,897
West Virginia	111,000	17.9%	19,869
Wisconsin	474,000	20.4%	96,696
Wyoming	67,000	15.0%	10,050

² Kaiser Family Foundation (April, 2014) Marketplace Enrollment as a Share of Potential Marketplace Population.

³ SAMHSA (2013) Enrollment under Medicaid Expansion and Health Insurance Exchanges: 2008-2010 National Survey of Drug Use and Health.

APPENDIX 4:

Glossary

Coinsurance: When the beneficiary, the person who has health insurance, shares the cost of a covered service. This is calculated as a percent (for example, 20%) of the allowed amount for the service. For example, if the allowed amount for an office visit is \$100 and the beneficiary has met their deductible, the co-insurance payment of 20% would be \$20. The health plan pays the remaining allowed amount. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

Copayment: A fixed amount (for example, \$15) the beneficiary pays for a covered health care service, usually at the time of service. The amount can vary by the type of covered health care service. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

Deductible: The amount the beneficiary owes for covered health care services before the health insurance begins to pay. For example, if the deductible is \$1,000, the plan will not pay for anything except preventive services until the beneficiary has paid \$1,000 for covered health care services. The deductible does not apply to preventive services such as annual check-ups or mental health screening, meaning that the plan will pay regardless of whether the deductible has been met. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

Depression Screening Tools: Brief questionnaires designed to detect the presence of depression. These tools are not diagnostic, but are used as preventive care to help determine whether the person could benefit from assessment by a mental health professional.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list. (<https://www.healthcare.gov/glossary/>)

Out of Pocket Limit: The amount owed by a beneficiary during a policy period before the health insurance plan begins to pay 100% of the allowed amount. This limit does not include the premium, balance-billed charges or costs for benefits not covered under the plan.

Network: The facilities, providers and suppliers the health insurer has contracted with to provide health care services. (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>)

Preventive Care: Routine health care that includes screening, check-ups and patient counseling to prevent illnesses, disease or other health problems. Under the ACA, all Marketplace plans and many other plans must cover a list of preventive services without charging a copayment or coinsurance. This is true even before the deductible is met. Depression screening is an example of preventive mental health care.

Prior authorization: A decision by the health insurer that a health care service, treatment plan or prescription drug is medically necessary. Sometimes called preauthorization, prior approval or precertification. (<https://www.healthcare.gov/glossary/>)

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness or condition and that meet accepted standards of medicine. (<https://www.healthcare.gov/glossary/>)

Non-Quantitative Treatment Limits (NQTL): Procedures to limit the scope or duration of benefits that do not involve a numerical value in terms of visits, days or costs. NQTLs may include such practices as prior authorization, step therapy and other utilization management techniques to determine whether a given service is medically necessary. Under the ACA, NQTL may be no more restrictive for mental health or substance use care than for medical or surgical care.

Prior Authorization (also called Prior Approval): A cost-containment procedure that requires a physician, facility or program to obtain permission from an insurance company or managed care organization before commencing treatment or prescribing a medication.

Quantitative Treatment Limits (QTL): Procedures to limit the scope or duration of benefits that involve a numerical value in terms of visits, days or costs. Examples include the number of visits or inpatient days, copays, coinsurance or annual dollar limits. Under the ACA, QTL may be no more restrictive for mental health or substance use care than for medical surgical care.

Step Therapy: Step therapy is a type of prior authorization. With step therapy, in most cases, you must first try certain less expensive drugs that have been proven effective for most people with your condition before you can move up a “step” to a more expensive drug. For instance, your plan may require you to first try a generic prescription drug (if available), then a less expensive brand-name prescription drug on its formulary, before it will cover a similar, more expensive brand-name prescription drug. (<https://www.medicare.gov/Pubs/pdf/11136.pdf>)

Tier: A health insurance term to indicate a level of coverage for a given type of care. For example, beneficiaries would pay more out of pocket costs for prescription drugs placed on higher tiers.

Utilization Management: Practices used by insurers to evaluate whether requested care is medically necessary, efficient and in line with accepted medical practice. Examples of utilization management practices include prior authorization and step therapy.

APPENDIX 5:

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