Report documents pervasive shortcomings in US mental health insurance

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In May, the National Alliance on Mental Illness (NAMI) released a report finding that individuals seeking mental health treatment in the US are twice as likely to have their claims denied by insurers than patients filing claims related to traditional medical procedures.

The report, titled *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care*, describes numerous systemic barriers to achieving mental health parity in the United States. It highlights the extent to which insurance companies have circumvented legislation requiring them to offer mental health benefits on par with other medical and surgical benefits.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), a law stipulating that insurance plans including mental health benefits must provide such benefits in the same manner as any other medical benefits. The stated intent of the law was to eliminate the higher copayments and deductibles charged by insurers, as well as to address instances of outright denial of mental health claims.

NAMI's report is valuable because it not only reveals the gaping chasm in coverage despite the parity law, but shows how the Affordable Care Act (ACA), popularly known as Obamacare, has failed to make any substantial advance in the provision of mental health services.

Notably, the MHPAEA did not include a simple mandate for insurers to offer mental health coverage, but only required equality between the terms and costs associated with mental health and those established for other health benefits. In 2010, the ACA extended these parity requirements to insurance plans sold on its federal and state exchanges. Mental health and substance abuse services were also included among various medical procedures that were required to be offered on all plans available through the exchanges.

However, neither of these two laws erased the longstanding discrepancy between insurance coverage for mental health conditions and coverage for other medical conditions.

The NAMI report points to the broader problem of a severe shortage of qualified mental health professionals in most areas of the US, especially in the country's more rural regions. Fifty-five percent of US counties do not have any practicing mental health professionals at all.

A similar shortage extends to plans offered through Obamacare's health insurance exchanges because many mental health professionals are not actually available to see patients at any given time. For instance, a January 2015 finding by the Mental Health Association of Maryland shows that only 14 percent of the psychiatrists within the state's exchange were actually available for an appointment within 45 days.

Even when a professional is available, private insurance companies commonly evade parity statutes by including clauses in mental health coverage plans regarding "medical necessity," through which services rendered are then arbitrarily deemed "unnecessary." Insurance companies engaging in this practice have essentially created their own private standards for what warrants coverage. The report notes that these standards, typically unclear and unavailable to patients, are common to plans covered by both the MHPAEA and the ACA.

Another prohibitive barrier is the out-of-pocket costs associated with either psychotherapy or psychiatric medication. Insurance companies typically cover prescription medications on a "tiered" basis, where higher-tiered medications have higher copays or

coinsurance costs, if they are not excluded altogether.

According to NAMI, psychiatric medication is actually somewhat more likely to be fully or partially covered than other medications on both private and ACA exchange plans. However, despite the higher likelihood of these medications being covered, partial medical coverage can still leave prohibitively large out-of-pocket costs that must be paid by the individual seeking treatment. NAMI states that 17 percent of surveyed respondents reported being unable to fill a prescription for a mental health condition because of out-of-pocket costs, while 30 percent reported being unable to do so for a substance abuse disorder.

More respondents reported out-of-pocket costs in the form of deductibles, copays and coinsurance as preventive barriers to inpatient or outpatient mental health care than for primary health care or specialty inpatient or outpatient care. Again, this finding was independent of whether the plan was available privately or through the ACA exchanges. The NAMI report states that if this data reflects an objective difference in out-of-pocket costs rather than distinct reactions by patients and their families to different forms of medical care, then at least some insurers must be in violation of parity laws.

Additionally, many families mentioned having to pay substantial deductibles regardless of the type of insurance they had or the source of the insurance. The cost of deductibles was markedly higher for plans available through the ACA. The most common deductible rate charged by insurance companies was in the $1,000-$2,500 range, while deductibles through private insurance plans are often much lower. In contrast, ACA plan deductibles are commonly much higher, with 22 percent of ACA plans charging deductibles in the $5,000-$10,000 range.

Two final problems listed in the NAMI report are insufficient information from insurers regarding what is actually covered by the plans they offer and the complicated legal framework for enforcing mental health parity.

Taken together, these two issues make it extremely difficult to assess whether insurance companies are following the parity law and how patients should intervene if they are not. In fact, in the seven years since MHPAEA was passed, the federal government has not taken a single enforcement action against an insurance company.

This is despite the fact that since 2010 the Department of Labor has found 140 instances of patients' parity rights being violated. A spokesman for the department said that all of the cases were settled on a voluntary basis with the relevant parties, but none of these settlements have been made public.

The disparities in the provision of mental health services is one more indication that US health care policy is dictated according to the demands of the private insurers, not by the medical needs of the population. The passage of the ACA was aimed at rationing care and shifting the costs paid by employers, insurers and the government onto individuals.

Obamacare was crafted in consultation with the insurance giants, which possess enough political clout to increase their profits through the "individual mandate" requiring people to purchase coverage, while ignoring other aspects of the law that are unfavorable to their interests.

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