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Title:

Burden of Proof: Insurance companies are refusing to pay for mental healthcare and regulators are letting them. Patients are left to fend for themselves.

Abstract:

When their mental health claims are denied, patients who are supposed to be protected by state and federal law have a choice: Don't get care or pay for the care themselves, then fight to get paid back.

Article:

Donna Kelly was not expecting an easy pregnancy. She had lived with an eating disorder her entire adult life and knew the condition would make it harder to handle the changes her body would soon experience.

A lawyer in Brooklyn who works with low-income medical patients, Kelly, 33, prepared herself by scheduling appointments with a high-risk obstetrician and, to monitor her eating disorder, her longtime primary care doctor.

But as she got further along, "it was starting to feel very out of control for me," she said. She was not able to follow her nutritionist's advice. Throwing up from morning sickness turned into *wanting* to throw up. Binging and purging several times per day, she was anemic, and there was a risk that if she didn't get more help, her baby would not grow.

In late December, she signed up for a partial hospitalization program that would monitor what she ate. As she waited for the program to begin in January, Kelly, now more than seven months pregnant, was worried about more than her health. The eating disorder program would cost up to \$20,000 a month, but her insurance company, Oxford Health, had already denied coverage of the much less expensive nutritional counseling she'd been receiving.

Kelly had appealed that decision, citing state and federal law that requires insurers to cover mental health treatment equal to medical and surgical treatment. She couldn't wait for their

decision, but she didn't have cash to pay for the treatment. She put it on her credit card and hoped for the best.

Kelly's story would be familiar to millions of people across the country. Patients pay more than double the share of inpatient mental healthcare than they do for comparable medical care, according to an analysis of major insurance companies' own data.¹ And according to the actuarial firm Milliman, office visits to a therapist or psychiatrist are five times more likely to be out of network.²

Bills signed into law by Presidents Bush and Obama were supposed to make these disparities a thing of the past. But a decade after the first bill, insurance companies are still paying less for mental healthcare. They have begun relying on mental health claims that are harder to track, and in some cases state and federal regulators aren't pressing insurers to prove they're following the law at all. On the federal level, regulators do not even have the power to investigate insurance companies or fine them for violating the law.

The result is a system that assumes insurers are doing the right thing while relying on individual patients to enforce the law, said Jennifer Snow, the public policy director for the National Alliance on Mental Illness (NAMI). That system is hard to navigate even for experts, she said, let alone an average person who is consumed with the mental health of themselves or a loved one.

Those patients end up with treatment delayed or denied, with medical bills put on credit cards or sent to collections. In some cases, they might not get treatment at all.

"If there's a time when dealing with paperwork is not a priority," said Snow, "I think a mental health crisis is the definition of that."

"Not a pleasant process"

Denials, delays, and under-reimbursement make getting healthcare harder for the 45 million people with mental illness in the U.S,³ 60 percent of whom do not receive treatment or medication at all.⁴ In the middle of the opioid crisis, the consequences of a lack of access are clear. At least 71,000 people died from drug overdoses last year,⁵ but fewer than 1 in 5 people with substance use disorder received any treatment, and barely 1 in 10 got treatment at specialty facility.^{6,7} Access also bears on another crisis. The suicide rate has been rising 2 percent each year since 2006.⁸

The insurance industry says its hands are tied. It is harder to approve mental healthcare because there is not enough evidence to show which treatments work, unlike medical and surgical treatment, said a spokesperson for America's Health Insurance Plans.

Insurers also need to keep medical costs down, said Frederick Villars, one of three doctors who approves and denies mental healthcare claims for Aetna. A former practicing psychiatrist, he remembers the hassle of arguing with insurers to approve treatment he prescribed.

"It's not a pleasant process," said Villars, "but it's the only tool that exists in this setting to try to keep costs under control." He also acknowledged that insurance companies are businesses that want to save money.

But controlling costs and turning a profit falls on the back of people who are in desperate need of help. After her insurance company denied her claims for nutrition, Kelly, who was purging food in her third trimester of pregnancy and needed supervision to eat meals, had no choice to pay for the program but go \$35,000 in debt.

Today, Kelly and her baby are both healthy. She feels fortunate that she had the wherewithal to go into debt and fight her insurer. Without it, she does not think she would have gotten the treatment she needed.

Being seriously ill while pregnant and fighting with her insurance company "was a mix of panic, frustration, and helplessness," she said. In between counseling and supervised meals at the eating disorder program, Kelly would call the Attorney General's office to follow up on her complaint.

Eventually, it worked. After talking with the Attorney General's office, Kelly's insurance company agreed to approve her appeal.

That wasn't the end of her story, though. Winning complaints and appeals has not gotten Kelly her money back. Nine months later, she said, Oxford continues to deny claims for nutritional counseling, and still owes \$15,000 for her treatment.

At the time of this writing, a spokesperson for UnitedHealthcare, the parent company of Oxford Health Plans, said the organization was gathering information for a response to Kelly's claims.

“It makes you really scared”

For nearly the entire history of modern American healthcare, there was nothing to stop insurance companies from refusing to cover mental healthcare or charging far more for it. It wasn't until 2008 that the federal government passed a law forcing health plans covering mental health to cover it equally with physical health. Two years later, the passage of Obamacare required nearly all plans to cover mental health. Equality of mental and physical health would be the law of the land.

That the laws are on the books hasn't helped Ellen Eskenazi. By the fall of 2016 her daughter, then 16, had dealt with anxiety and depressive disorders for several years, but now it was getting worse.

After researching programs that could help her daughter, she found Mountain Valley Treatment Center, a nonprofit residential program in New Hampshire. But the program cost more than \$100,000, requiring families to pay up front and submit their own claims to insurance.

In the program, her daughter started recovering. Then the family's insurance company, Aetna, said it would not pay for the program after 30 days because it would no longer be medically necessary. The family appealed the decision while their daughter stayed in the program for several more months, returning home to New York City early this summer.

Medical necessity reviews are one of the main ways that insurance companies overturn or scale back treatment made by therapists and psychiatrists. After federal laws forced insurers to cover mental health equally, violations written into plans — such as caps on treatment separate deductibles for mental healthcare — were easily spotted and shut down by regulators. So insurance companies leaned on their ability to launch challenges of coverage based on their interpretation of a health plan.

Eric Plakun, the medical director of the Austen Riggs Center, a non-profit residential treatment center in western Massachusetts, said insurance companies are “using the wrong criteria” for what makes something medically necessary. They pay enough only to stabilize someone’s condition, but not actually to improve it, he said.

Villars, the Aetna doctor, said that he understands why providers like Plakun are upset. But he said the problem isn’t that insurers aren’t applying industry guidelines fairly — it’s that providers don’t like the guidelines.

Denial of medication or treatment until providers submit additional proof is another common challenge. So are “fail-first” policies, which force patients to exhaust cheaper treatment options, regardless of what their doctor thinks they need, before getting what their doctor prescribes. A person addicted to opioids, for example, may be forced to try a low-cost day treatment program when, because of their risk of overdose, they need to be in a 24/7 rehabilitation program.

These violations of parity laws are much more difficult to prove, because the violations aren’t written into the health plan. In most states, insurers don’t have to report their compliance with parity laws to state regulators, let alone to the public.

But in the aggregate, it is clear these tactics are being used because the data shows unequal coverage of mental and medical benefits. In the four years ending in 2016, consumers spent seven times as much out of pocket on inpatient mental healthcare compared to its equivalent in medical and surgical care, even though the cost of each grew by the same amount, according to

data from the Health Care Cost Institute, a think tank funded by four major health insurance companies.⁹

Six months after her daughter returned home, Aetna has refused to pay more than an additional 10 days' worth of the program, leaving Eskenazi's family with \$60,000 of the bill. Because the policy covers 60 percent of mental health, Aetna should pay at least another \$20,000, she said. Their plan pays 33 percent more for medical benefits, which is an illegal disparity.

The family continues to appeal, but Eskenazi is more concerned about the future. What happens if her daughter gets sick again? Knowing that insurance won't cover treatment, she is arranging with her husband to have money available for an emergency. The whole process leaves her feeling vulnerable.

"It makes you really scared," she said.

"The insurance company hopes you'll drop it"

Elizabeth was finally feeling better.

After unsuccessful treatment with a standard antidepressant, her psychiatrist prescribed her a drug normally used for a different neurological condition. The effect of the new drug, Nuedexta, was amazing. Her psychiatrist's research found it activated the same brain receptors as the drug ketamine, currently being used in trials for depression.

Elizabeth continued improving on the drug. Then a year later, she received a letter from her insurer, UnitedHealthcare.

The letter said that because Nuedexta was FDA-approved for a different neurological condition, it should never have been authorized without permission from the insurer ahead of time. She

would not be allowed to refill the prescription unless her psychiatrist convinced the insurance company why a drug, which had been easing her depression for the last year, was necessary.

If anyone could be prepared for the vagaries of insurance claims, it would be Elizabeth. As an insurance liaison for a substance use rehabilitation center in St. Louis, she tries to convince insurance companies to pay for her clients' treatment every day.

"I've seen many, many ridiculous denials for people who clearly needed inpatient treatment," said Elizabeth, who asked her name to be withheld so not to affect her work, in an email.

Now, faced with the loss of her own medication, she didn't know what to do.

What could have been a harmful setback was avoided, though, when her psychiatrist convinced UnitedHealthcare to reauthorize Nuedexta. Today she is still doing well, and even hopes to taper off the drug.

For those whose pleas to insurance reviewers are not successful, there is another option. Appeals of coverage denials sometimes work.

Of the 10 to 20 percent of denials that are appealed to his team at Aetna, said Villars, about 4 in 10 of the appeals are granted. If they're denied again, customers can make one more appeal. For this second round of appeals, Aetna and other insurance companies contract with independent reviewers. For Aetna customers, those appeals succeed about half the time, Villars said.

Plakun, the clinic director who is critical of insurers, shared a similar estimate. He said that if the third-party reviewer is truly independent of the insurance company, appeals succeed about 60 percent of the time.

"A good appeal has a decent chance," he said.

But there is a catch. Because appealing often takes lots of time, paperwork, and phone calls to your insurer, the bureaucratic process for getting a denial reversed can take months. In the

meantime, you have a choice: Forgo care or front the cash and hope that insurance will cover it later.

The combination of expense and hassle work to the insurer's benefit.

"The insurance company hopes you'll drop it," said Plakun, who has written and spoke on how to make appeals. Still, he said, winning the appeal is possible.

"If you stick with it, and you document carefully," he said, "there's a good chance that you can prevail in these things."

Policyholders can also file complaints to insurance regulators, but few do so. In New York, the Department of Financial Services (DFS) is responsible for investigating complaints by consumers against most private health plans. The agency said it received just 49 complaints about parity from 2013 to 2017. In 20 cases, the ruling was made in the consumer's favor.

Snow, the public policy director for NAMI, said the small number of formal complaints is probably the result of consumers not having the knowledge or wherewithal to file them with state or federal agencies.

"It's all about what regulators are doing"

As a public policy adviser for The Kennedy Forum, a mental health advocacy group, David Lloyd is in the odd position of lobbying state legislatures to pass laws that are, strictly speaking, not necessary.

For the most part, bills granting insurance commissioners specific enforcement powers for mental healthcare are not needed at all, he said.

"The regulators in most states," he said, already "have the power to enforce the federal parity act."

In other words, the bills aren't written to give them new powers. They are written to make sure they use the power they have.

“Ultimately,” he said, “it’s all about what regulators are doing to enforce the law,” and “it’s fair to say that most insurance departments have not always aggressively enforced parity laws.”

In Illinois, for example, Lloyd said the Department of Insurance (DOI) had not checked in more than a quarter century to see whether the state’s largest insurer, Blue Cross and Blue Shield of Illinois, was covering claims as advertised in its health plans. Now, with a bipartisan law signed in August, the DOI will be required to audit private and public plans for compliance.

Laws in other states have tried to hem in their insurance commissioners as well. Colorado and New York have set up mental health ombudsman programs that could give frustrated insurance customers a more independent outlet for their complaints. Tennessee and Illinois have passed, and New Jersey is considering, laws to require public and private insurers to report on how they’re complying with parity. In Illinois, legislators took another step to directly bar insurance company practices that held up treatment for people with opioid addiction.

There are several reasons why state regulators don’t use their enforcement powers, said Ellen Weber, who directs the Parity@10 campaign calling attention to the issue a decade after the passage of the landmark federal law.

Some regulators believe their only role is to make sure health plans are financially sound. Other regulators, she said, think their department doesn’t have the expertise to intervene.

Then there are those, Weber said, who have been co-opted by the insurance industry.

The coziness of insurance commissioners with the companies they regulate is well-documented. An investigation by the Center for Public Integrity in 2016 found that insurance commissioners and their staff often take jobs with insurance companies, attend swanky company-sponsored events, receive large campaign contributions from them, and even have investments in them or spouses who work at them.¹⁰

Enforcing parity is inconsistent across state insurance commissioners, said Snow, the public policy director for NAMI. She has heard several state insurance commissioners say that their states receive few complaints or virtually none at all.

“I think they are probably all aware of it,” she said of the gap between mental and physical health claims, but “some state commissioners have taken less action than others.”

In the absence of aggressive regulation, closing the gap between reimbursement for mental and physical health claims may come from the last place anyone would expect: bipartisan groups of politicians.

Republicans, traditionally skeptical of expanding insurance protections, have joined Democrats in coalitions to strengthen state and federal parity laws. This year, bipartisan sponsors advanced bills in Colorado and New York, where they were signed by Democratic governors, and in Illinois and Tennessee, where they were signed by Republican governors.¹¹

Bipartisanship on the issue has extended to the hyper-partisan halls of Washington — to an extent.

President Donald Trump’s opioid commission, which included two Democratic chairs, recommended in late 2017 to give the Labor Department authority to investigate and fine insurers for violating parity in the self-funded insurance marketplace. Without either power, Labor has cited just 307 violations of the law since it took effect in late 2009.¹

Trump’s popularity among Republicans, however, was not strong enough in the Senate committee voting on the recommendation. The bill was voted down by Republican members in the spring.^{12,13}

The lack of attention to the problem leaves patients to fend for themselves. At her home in Brooklyn, Kelly's nine-month-old bounces himself up and down on her lap as she pages through several binders' worth of letters both to and from her insurance company. Despite winning an appeal with her insurer and an outside complaint with the state attorney general, her claims for nutritional counseling continue getting denied.

"It's a contract," she said. "I'm paying my premium, now it's your job to apply the reimbursements properly."

ENDNOTES

¹ <https://www.healthcostinstitute.org/research/annual-reports/entry/2016-health-care-cost-and-utilization-report>. Health Care Cost Institute: 2016 Health Care Cost and Utilization Report, 2018-06-19. Accessed 2018-12-13.

² <http://milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf>. Milliman Research Report: Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates. December 2017. Accessed 2018-12-16.

³ <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>. “Mental illnesses are common in the United States. Nearly one in five U.S. adults lives with a mental illness (44.7 million in 2016).” Accessed 2018-12-09.

⁴ <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#mhuse5>. Figure 63 Table. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older with Any Mental Illness in the Past Year: Percentages, 2008-2016. Accessed 2018-12-09.

⁵ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>. Provisional Drug Overdose Death Counts. “Data Table for Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths”. Accessed 2018-12-09.

⁶ <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#tx>. Accessed 2018-12-09. In 2016, 21 million people needed substance use treatment, 3.8 million received some form of it (18.1%), and 2.2 million received treatment at a specialty facility (10.5%).

⁷ The previous four endnotes citing sources that were found through the following article: <https://www.healthaffairs.org/doi/10.1377/hblog20181009.356245/full/>. Lindsey Vuolo, Robyn Oster, Ellen Weber. “Evaluating The Promise And Potential Of The Parity Act On Its Tenth Anniversary”. Written 2018-10-10. Accessed 2018-12-09.

⁸ <https://www.cdc.gov/nchs/products/databriefs/db330.htm>. “From 1999 through 2017, the age-adjusted suicide rate increased 33% from 10.5 per 100,000 standard population to 14.0 (Figure 1). The rate increased on average by about 1% per year from 1999 through 2006 and by 2% per year from 2006 through 2017.” Accessed 2018-12-13

⁹ See previous note for Health Care Cost Institute: 2016 Health Care Cost and Utilization Report.

¹⁰ <https://publicintegrity.org/state-politics/drinks-dinners-junkets-and-jobs-how-the-insurance-industry-courts-state-commissioners/>. Drinks, dinners, junkets and jobs: how the insurance industry courts state commissioners. By Michael J. Mishak. Published 2016-10-03. Accessed 2018-12-17.

¹¹ State breakdown:

Illinois - Dem legislature, GOP governor. Sponsored by three GOPs in House. Signed 2012-08-22. <https://www.apnews.com/33e6d54fe11b4e1b8849308ef309b560>

Colorado - Co-sponsored in state senate by a Republican. Signed 2018-05-24. <https://leg.colorado.gov/bills/hb18-1357>

New York (not yet signed) - Sponsored in the state senate by a Republican. Passed legislature June 20, 2018. <https://www.nysenate.gov/legislation/bills/2017/a3694>

Tennessee - Signed by GOP governor, co-sponsored by Democrat and Republican in House. Signed May 21, 2018. <https://legiscan.com/TN/text/SB2165/2017>

Original article source: <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.8b8>

¹² Calculations:

a. FY10-17 numbers (FY10-15* + FY16-17**) = 1,892 investigations 307 violations.

b. Percentage that were NQTL calculated by adding NQTL shares of violations of each period (171 violations FY10-15 * 58 percent NQTL = 99 violations NQTL; 136 violations FY16-17 * 48.91 percent NQTL = 67; 99+67=166).

*FY10-15 statistics: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/improving-health-coverage-for-mental-health-and-substance-use-disorder-patients.pdf>.

**FY16-17 statistics: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf>.

¹³ <https://www.murphy.senate.gov/newsroom/press-releases/republicans-reject-murphys-amendment-to-enact-trump-opioid-commission-recommendations-to-hold-insurance-companies-accountable>. Republicans Reject Murphy's Amendment To Enact Trump Opioid Commission Recommendations To Hold Insurance Companies Accountable. 2018-04-24. Accessed 2018-12-14.