NEWS

Mental health coverage lags behind physical, despite laws promising parity

BY **GRAISON DANGOR, KAISER HEALTH NEWS**

10 JUNE 2019

Amanda Bacon's eating disorder was growing worse. She had lost 60 percent of her body weight and was consuming about 100 calories a day.

But that wasn't sick enough for her Medicaid managed-care company to cover an inpatient treatment program. She says she was told in 2017 that she would have to weigh 10 pounds less — putting her at 5-foot-7 and 90 pounds — or be admitted to a psychiatric unit.

"I remember thinking, 'I'm going to die,'" the Las Cruces, New Mexico, resident recalls.

Eventually, Bacon, now 35, switched to a plan that paid for treatment, although she says it was still tedious to get services approved.

Many people like Bacon struggle to get insurance coverage for their mental health treatment, even though two U.S. federal laws were designed to bring parity between mental and physical healthcare coverage. Recent studies and a legal case suggest serious disparities remain.

The 2008 **Mental Health Parity and Addiction Equity Act** required large group health plans that provide benefits for mental health to put that coverage on an equal footing with physical health. Two years later, the Affordable Care Act required small-group and individual health plans sold on the insurance marketplaces to **cover mental health services** and to do that at levels comparable with medical services. (In 2016, parity rules **were applied to Medicaid** managed-care plans, which cover the majority of people in that federal-state health program for low-income residents.)

The laws have been partially successful. Insurers can no longer write policies that charge higher copays and deductibles for mental health care, nor can they set annual or lifetime limits on how much they will pay for it. But patient advocates say insurance companies still interpret mental health claims more stringently.

"Insurance companies can easily circumvent mental health parity mandates by imposing restrictive standards of medical necessity," says Meiram Bendat, a lawyer leading a class-action lawsuit against a mental health subsidiary of UnitedHealthcare.

Shortchanging claims:

In a **closely watched ruling**, a federal court in March sided with Bendat and patients alleging the insurer was deliberately shortchanging mental health claims. Chief Magistrate Judge Joseph Spero of the U.S. District Court for the Northern District of California **ruled that United Behavioral Health** wrote its guidelines for treatment **much more narrowly** than common medical standards, covering only enough to stabilize individuals "while ignoring the effective treatment of members' underlying conditions."

UnitedHealthcare works to "ensure our products meet the needs of our members and comply with state and federal law," says spokeswoman Tracey Lempner.

Several studies, though, have found evidence of disparities in insurers' decisions.

In February, researchers at the **Congressional Budget Office** reported that private insurance companies are paying 13 to 14 percent less for mental health care than Medicare does.

The insurance industry's own data show a **growing gap** between coverage of mental and physical care in hospitals and skilled nursing facilities. For 2013 to 2017, out-of-pocket spending on inpatient mental health care grew nearly 13 times faster than all inpatient care, according to inpatient data reported in February by the **Health Care Cost Institute**, a research group funded by the insurance companies Aetna, Humana, UnitedHealthcare and Kaiser Permanente. (*Kaiser Health News* is not affiliated with Kaiser Permanente.)

And a **2017 report** by the actuarial firm Milliman found that an office visit with a therapist is five times as likely to be out-of-network, and thus more expensive, than a primary care appointment.

In this environment, only half of the **nearly 8 million children** who have been diagnosed with depression, anxiety or attention deficit hyperactivity disorder receive treatment, according to a **February research letter** in *JAMA Pediatrics*. **Fewer than 1 in 5** people with substance use disorder are treated and, overall, **nearly 6 in 10** people with mental illness get no treatment or medication.

Amanda Bacon, who is still receiving care for her eating disorder, says she remembers fearing that she wouldn't get treatment. She was at one point rushed to an emergency room for care, but after several days she was sent home, no closer to getting well.

Today, because of her disability, Bacon's primary insurance is through Medicare, which has paid for treatment that her earlier Medicaid provider, Molina Healthcare, refused. She has been treated in four inpatient programs in the past two years — twice through Presbyterian Centennial Care, a Medicaid plan she switched to after Molina, and twice though her current Medicare plan. Bacon is also enrolled in a state-run Medicaid plan.

Molina said it could not comment on Bacon's case. "Molina complies with mental health parity laws," said spokeswoman Danielle Smith, and it "applies industry-recognized medical necessity criteria in any medical determinations affecting mental health."

The 'wrong criteria':

Eric Plakun, chief executive officer of the Austen Riggs Center, a psychiatric hospital and residential program in Massachusetts, says that often insurers are "using the wrong criteria" for what makes something medically necessary. They pay enough to stabilize a person's condition, he says, but not enough to improve their underlying illness. Plakun was one of the experts who testified in the case before Judge Spero in California.

Insurers say they recognize the importance of mental health care coverage and that they are **complying with the law**.

Cathryn Donaldson, a spokeswoman for the trade group America's Health Insurance Plans, says

that the industry supports parity but that it is also harder to prove when mental health treatment is needed.

Compared with medical and surgical care, the data and standards to measure mental health care "trail far behind." She cites **a 2016 study** of Minnesota hospitals, where nearly one-fifth of the time individuals spent in psychiatric units occurred after they were stabilized and ready to be discharged.

"Just like doctors use scientific evidence to determine the safest, most effective treatments," insurers do the same to cover treatment "consistent with guidelines showing when and where it's effective for patients," Donaldson says.

Health plans commonly apply several controls for mental health care. The techniques are legal — unless they are applied more strictly for mental health care than medical care.

They often require people to try cheaper options first, a strategy called "fail first." Individuals referred by their doctors to a residential program for opioid addiction, for example, might be denied by their insurers until they try, and fail, to improve at a less expensive part-time program.

Hiring doctors, nurses and pharmacists to review claims is another technique.

Frederick Villars, who reviews mental health claims for Aetna, remembers arguing with insurers to approve treatment when he was a practicing psychiatrist. His team decides what to cover based on clinical standards, he says, and providers upset about a coverage decision "are well aware of what these guidelines are."

"It's not a pleasant process," he says, "but it's the only tool that exists in this setting to try to keep costs under control."

*This story originally appeared on **Kaiser Health News**. It has been slightly modified to reflect* Spectrum's *style.*