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Mental Health Parity at Risk

Deregulating the Individual Market and the Impact on Mental Health Coverage

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National Alliance on Mental Illness

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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.

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EXECUTIVE SUMMARY

Before the Affordable Care Act (ACA), the individual health insurance market was riddled with persistent problems of availability, affordability and adequacy for people with mental health and substance use disorders. The ACA changed this by remedying discrimination against people with preexisting conditions and requiring coverage of mental health and substance use treatment services in the individual market. With the regulatory requirements that such coverage be comprehensive and provided at parity with other medical coverage, individuals no longer faced unequal limits on mental health and substance use treatment coverage. However, efforts are underway to weaken the individual market protections in the ACA.

Our research of the individual health insurance market prior to the ACA, including analysis of individual health insurance policies offered in eight states and interviews with current or former insurance executives, consultants and actuaries, found:

Most States Had No Requirement that Individual Market Health Insurance Plans Cover Mental Health Services

Twenty-eight states had no mandate that individual market plans cover or even offer mental health services before the essential health benefits (EHBs) requirement in the ACA took effect. Five states required insurers to offer mental health coverage in the individual market, but allowed plans to be sold without such coverage. Eight states that mandated mental health coverage allowed coverage to be limited to only serious mental illness or biologically-based mental illness.

Health Plans Sought to Avoid Enrolling Individuals with Mental Health or Substance Use Conditions

Insurers asked enrollees questions about their health history, such as “Are you getting counseling?” and “How many meds are you taking?,” as part of a screening process called medical underwriting. People with preexisting mental health or substance use conditions would routinely be denied coverage altogether or offered coverage that was much more expensive or excluded the services they were likely to need.

When Individual Market Insurance Was Accessible, It Was Often Unaffordable and Inadequate for Individuals with Mental Health or Substance Use Conditions

Insurers effectively fined people with a history of mental health or substance use conditions by applying a 20 percent to 50 percent increase in premium

cost. Some plans excluded all mental health and substance use services. When covered generally by a plan, an insurer might exclude mental health and substance use services needed by an applicant, such as excluding all services used to treat a specific condition (for example, eating disorders) or all prescription drugs used for psychiatric conditions.

Benefit Limitations for Mental Health and Substance Use Services Made Coverage Superficial

Individual market plans commonly placed limits on the amount of mental health and substance use services, including outpatient visit limits and limits on inpatient days covered. Lifetime caps on coverage were also common. Some plans paid no more than $5,000 in mental health and substance use service claims in a lifetime.

Insurers Reduced Access to Mental Health and Substance Use Services Through Cost-Sharing Design and Utilization Management

Some insurers applied higher cost-sharing, such as higher copayments and coinsurance, to mental health and substance use services. Aggressive use of utilization management for mental health and substance use services meant many enrollees were discouraged or prevented from accessing coverage for needed services. Cumbersome utilization management techniques included 45-minute phone consultations for prior authorization of services or denying non-mental health treatment when related to a mental health diagnosis.

Restricted Access to Prescription Drugs Further Limited Coverage for Mental Health Treatments

Some plans provided no prescription drug benefits at all. When prescription drugs were covered, coverage might be insufficient. Plans that excluded mental health and substance use services also excluded drugs to treat these conditions. In some cases, plans only covered generics or placed drugs to treat mental health or substance use disorders on a higher cost-sharing tier.

Flexibility in the Essential Health Benefits and Loss of Parity Rules Could Mean a Return of Limits and Exclusions in Mental Health and Substance Use Treatment Coverage

Although insurance industry experts interviewed said there is now a greater understanding and acceptance of mental health and substance use disorders, many expect insurers to migrate back to the limited pre-ACA benefit designs

and utilization management practices if given greater flexibility over coverage of EHBs. If parity requirements are lost, multiple respondents expect the return of visit limits, dollar limits and higher cost-sharing for services related to mental health and substance use disorders.

Overall, the findings of this report suggest that weakening EHB standards or expanding access to coverage exempt from EHB standards could readily result in insurers moving to previous practices of limiting enrollment of people with mental health and substance use disorders and limiting access to services. The result would be that people, once again, would be left without access to insurance that provides financial protection and meets their mental health care needs.

OVERVIEW

The individual market has long been the only access point to coverage for millions of Americans who are ineligible for public coverage and do not have access to employer-based insurance. The Affordable Care Act (ACA) overhauled coverage of mental health and substance use treatment services for those buying health coverage in this market. Prior to the ACA, the individual market was closed to millions of Americans with preexisting conditions, and for those who could purchase a plan, provided coverage that was inadequate to meet mental health and substance use treatment needs.

Mental health and substance use disorders affect millions of Americans, with billions of dollars in health care and other economic costs. Almost 1 in 5 adults in the U.S. has a mental illness and about 1 in 25 has a serious mental illness.[1] The health care costs of mental health disorders exceed all other medical conditions, with a total cost of $201 billion in the U.S. in 2013.[2] Over 8 percent of Americans age 12 and older were classified with a substance use disorder in 2014, and the U.S. is in the midst of an unprecedented opioid crisis.[3] Accordingly, there is a high need for coverage of mental health and substance use treatment.

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[1] National Institute of Mental Health, "Any Mental Illness (AMI) Among Adults," National Institutes of Health, https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml (accessed October 19, 2017); National Institute of Mental Health, "Serious Mental Illness (SMI) Among Adults," National Institutes of Health, http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml (accessed October 19, 2017).

[2] Roehrig C, "Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion." Health Affairs, May 2016, http://content.healthaffairs.org/content/early/2016/05/13/hlthaff.2015.1659 (accessed October 19, 2017).

[3] Substance Abuse and Mental Health Services Administration, "Mental and Substance Use Disorders," U.S. Department of Health and Human Services, September 20, 2017, https://www.samhsa.gov/disorders (accessed October 19, 2017); U.S. Department of Health and Human Services, "The Opioid Epidemic: By the Numbers," June 2016, https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf (accessed October 19, 2017).

Before the ACA, health insurers in the individual market routinely denied coverage to people with preexisting conditions, including mental health and substance use disorders. Policies in the individual market covered fewer benefits and required higher cost-sharing than employer-based coverage.[4] When it came to mental health and substance use treatment, the coverage was even more limited—if it existed at all. This changed with the implementation of the ACA. The ACA eliminated discrimination against people with preexisting conditions by requiring guaranteed access to coverage, banning coverage exclusions for preexisting conditions and ending rating based on health status (which increased the premium a person with a health condition, or history of a health condition, paid) in the individual market. These ACA protections opened the door for many people with mental health and substance use disorders to enter the individual market. In total, 8.1 million more people received coverage through the individual market in 2016 than in 2013, just prior to implementing the market reforms.[5]

The ACA also required that plans in the individual market cover "Essential Health Benefits" (EHB), including coverage of mental health and substance use services. Further, the federal regulations implementing the EHB applied the Mental Health Parity and Addiction Equity Act (MHPAEA) to EHBs.[6] As a result, coverage of mental health and substance abuse services must be provided at parity with coverage of other medical services in all individual market plans.[7] This means, among other things, that plans cannot have more stringent visit limits or higher cost-sharing on mental health and substance use services than for comparable medical services. In addition, medical management policies, such as prior authorization and utilization review, cannot be materially different from those imposed on other medical benefits. Because the ACA prohibits annual or lifetime dollar value limits on the EHB, such limits are also no longer allowed for mental health and substance use services. For people with mental health or substance use disorders, this means that the coverage that is now accessible has adequacy standards that better meet their health care needs.

Efforts are underway in the Executive Branch to weaken the market protections in the ACA. Multiple bills have been proposed to repeal and replace the ACA that would have allowed states to eliminate the EHB requirements, including coverage of mental health and substance use services. While the ACA enshrined certain protections for people with preexisting conditions into

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[4] Corlette S, Volk J, and Lucia K, "Real Stories, Real Reforms," Robert Wood Johnson Foundation, September 2013, https://www.rwjf.org/en/library/research/2013/09/real-stories--real-reforms.html, (accessed October 19, 2017).

[5] Calculations based on data from Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed November 12, 2017).

[6] 45 CFR 147.160.

[7] Plans that existed prior to the passage of the ACA and have not made significant changes in cost-sharing or benefits may be grandfathered and therefore exempt from this requirement.

law, many protections were defined through regulations and guidance, which can be changed without congressional action. These changes will undermine the protections put in place in the ACA for people with preexisting conditions.[8] Since Congress's failure to repeal the ACA, the Administration has finalized regulation changes that weaken the standards for EHB and will allow states to significantly weaken any or all of the EHB category requirements, including mental health and substance use. The Administration has also proposed regulations that will expand access to coverage that is exempt from the EHB requirements.

To better understand what is at risk with returning to an individual insurance market that lacks federal mental health and substance use benefit requirements, this brief explores barriers and gaps in coverage of mental health and substance use treatment in the individual health insurance market coverage prior to enactment of the ACA. A combination of underwriting practices, coverage limitations and medical management practices put access, affordability and adequacy of coverage beyond the reach of many people in need of mental health and substance use treatment. The brief also explores the potential for return to these prior practices under new regulations that give states and insurers greater flexibility on the EHB. Our findings are based on an analysis of 30 individual health insurance policies offered in eight states in the years immediately prior to enactment of the ACA. In addition, our findings are informed by interviews with nine current or former insurance executives, consultants and actuaries working in the individual health insurance market.[9]

BACKGROUND

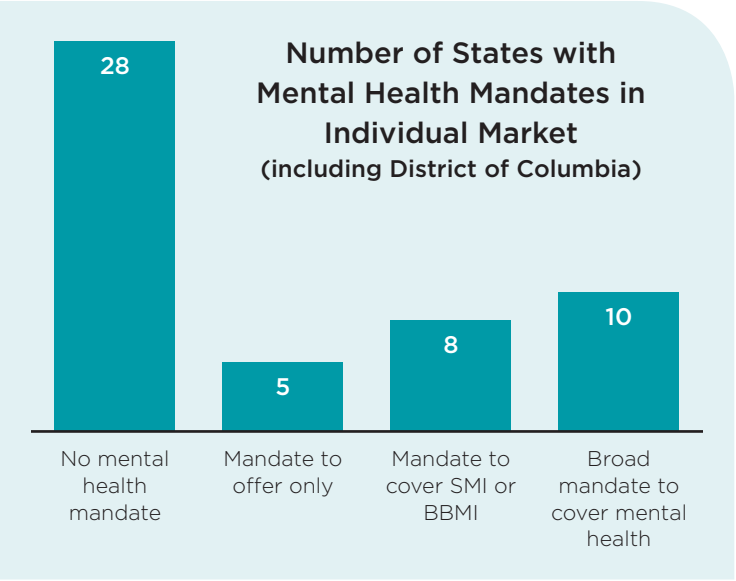
Prior to the ACA, state laws provided a patchwork of protections that left large gaps in coverage for people in the individual health insurance market who needed mental health services.[10] More than half of the states, twenty-eight, had no mandate that individual market plans cover or even offer mental

[8] "Definition of 'Employer' Under Section 3(5) of ERISA-Association Health Plans; Notice of proposed rulemaking," 83 Federal Register 614 (January 5, 2018), pp. 614-636. "Short-Term, Limited-Duration Insurance; notice of proposed rulemaking," 83 Federal Register 7437 (February 21, 2018), pp.7437-7447.

[9] Findings were supplemented by analysis of underwriting manuals from one insurer and agent guides from 6 insurers.

[10] Kaiser Family Foundation, "Pre-ACA State Mandated Benefits in the Individual Health Insurance Market: Mandated Coverage in Mental Health," https://www.kff.org/other/state-indicator/pre-aca-state-mandated-benefits-in-the-individual-health-insurance-market-mandated-coverage-in-mental-health/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed October 19, 2017).

health services.[11] Five states required that insurers *offer* mental health coverage, but allowed plans to be sold without such coverage. This meant insurers could charge more to individuals who wanted plans with mental health coverage.[12]



Source: Kaiser Family Foundation, Pre-ACA State Mandated Benefits in the Individual Health Insurance Market: Mandated Coverage in Mental Health

Those states that did require mental health coverage often allowed the coverage to be extremely limited. Eight states that mandated mental health coverage allowed coverage to be limited to only serious mental illness (SMI) or biologically-based mental illness (BBMI).[13] For example, Montana listed seven mental health conditions in state law that were considered "severe mental illness" that must be covered by plans in the individual market. The seven conditions were: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder and autism.[14] Kansas allowed plans to limit mental health services to a lifetime maximum benefit of $15,000.[15] Virginia allowed plans to limit outpatient services to 20 visits, with a 50 percent coinsurance after the first 5 visits, and to limit inpatient services to 20 days.[16] Only eight states required plans to cover and have parity for mental health services, which meant they could not have greater cost-sharing or more restrictive limits than other medical services.[17] Of those eight states, six required coverage of only SMI or BBMI.[18]

Minnesota had a mental health and substance use parity requirement but did not require that plans cover mental health or substance use services.[19] This meant that a plan could exclude all mental health and substance use services, but any services that were covered had to be at parity with other medical services. Some states had requirements to cover substance use treatment. For example, Michigan did not have a mandate to cover mental health services but did require that plans cover some substance use treatment.[20]

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[11] Kaiser Family Foundation, Pre-ACA State Mandated Benefits.
[12] Kaiser Family Foundation, Pre-ACA State Mandated Benefits.
[13] Kaiser Family Foundation, Pre-ACA State Mandated Benefits.
[14] Mont. Code Ann. § 33-22-706.
[15] Kan. Stat. Ann. § 40-2-105.
[16] Va. Code Ann. § 38.2-3412.1.
[17] Kaiser Family Foundation, Pre-ACA State Mandated Benefits.
[18] Kaiser Family Foundation, Pre-ACA State Mandated Benefits.
[19] Minn. Stat. § 62Q.47 (2008).
[20] Mich. Comp. Laws § 550.1414a.

Our review of individual market policies and practices found that insurers operating within these state laws used multiple tools to limit enrollment of individuals with mental health or substance use disorders and to limit access to mental health and substance use services for those who enrolled.

FINDINGS

Health Plans Sought to Avoid Enrolling Individuals with Mental Health or Substance Use Conditions Through Underwriting

Prior to the guaranteed issue and rating protections of the ACA, insurers in many states would discriminate against individuals with preexisting mental health and substance use conditions. Insurers would use a practice known as medical underwriting to screen applicants for current or past health conditions that might require treatment. An underwriter explained that, as part of the underwriting process, the insurer "would ask some questions to try and get to the severity and utilization of their illness" in an effort to determine an individual's risk. The term "risk" is associated with financial risk to the insurer. The higher the expected claims associated with an enrollee, the higher the enrollee's risk to the insurer. Based on this screening process, people with preexisting conditions would routinely be denied coverage altogether or offered coverage with a higher premium, known as a "rate-up," and/or an exclusionary rider that would exclude coverage for specified services or treatment of their preexisting condition(s).

Examples of Questions Asked During Underwriting

"How often do you go to the doctor?"

"When did you last go to the doctor?"

"Have you ever been hospitalized for this?"

"How many meds are you taking?"

"Are you getting counseling?"

Source: Authors' interview with insurance underwriter

> ***"More often than not, [a] person with serious mental illness would be excluded. Something more moderate or in remission, often those folks would be able to get coverage."***
>
> **— ACTUARY —**

Coverage Was Denied for Many Individuals

Many individuals with mental health or substance use conditions were denied coverage altogether. One actuary said "more often than not, [a] person with serious mental illness would be excluded"

from coverage. Another actuary noted that it could depend on the severity of the condition; a mild mental health condition would not necessarily result in denied coverage, but "if you're being hospitalized twice a year for some mental health condition," you would likely be denied.

The underwriting process would screen applicants for some specific conditions that resulted in automatic denial, preventing the applicant from purchasing coverage. As noted by a former executive with a behavioral health plan (a company that manages the mental health and substance use portion of coverage for health insurers), the applicant would be "dropped like a hot potato" if one of the specified conditions was discovered.

> *"We screened out alcoholism and other addictions because [they] can drive depression. If depressed, [there is] some overlap with alcoholism. Autism was always an exclusion, developmental delays was always an exclusion."*
>
> **— FORMER INSURANCE EXECUTIVE —**

One underwriter noted that some conditions, such as paranoid schizophrenia and severe personality disorders, resulted in automatic denial. Another respondent said underwriters "screened out alcoholism and addictions because [they] can drive depression." The product manager of a regional insurer said when individuals were rejected, they could turn to state high risk pools. However, with high premiums, high deductibles and lifetime limits, high risk pools failed to meet the needs of enrollees.[21]

When Individual Market Insurance Was Accessible, It Was Often Unaffordable and Inadequate

For individuals that passed underwriting, their mental health or substance use condition would often result in higher rates or specific exclusionary riders that excluded services needed to treat their condition. Although underwriting practices varied by insurer and even on a case-by-case basis, underwriting decisions were often based on the severity of the condition and whether the condition was considered chronic or temporary. For example, an underwriting manual

Key Underwriting Terms

Standard Rate: Lowest rate for a specific plan, typically charged to a person considered minimal risk.

Rate-Up: Rate increase applied to applicants with preexisting conditions, typically a percentage of the standard rate.

Specific Exclusionary Rider: Addition to the policy contract that excluded coverage of specified benefit categories or services to treat specific diagnoses.

[21] Pollitz K, "High Risk Pools for Uninsurable Individuals," Kaiser Family Foundation, February 2017, https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/ (Accessed October 18, 2017).

suggested a 20 percent rate increase, or rate-up, for an individual with a mild reactive depression in the previous six months. The same manual suggested an individual with a severe reactive depression episode within the past five years should have coverage declined.

In other cases, underwriting decisions were based on the presence of a specific condition, without regard to severity. For example, one underwriter said most insurers would deny coverage to applicants with a bipolar disorder diagnosis. But, she reported, she worked for an insurer where underwriting staff had sufficient medical knowledge to assess risk and offer coverage with features to protect against claims. For example, underwriters at this insurer would consider making an offer to an applicant with bipolar disorder if the medical history, including medication compliance, showed a low enough risk, but the coverage would come with rate-ups or exclusionary riders.

Rate-Ups and Exclusionary Riders Made Coverage More Expensive and Less Adequate for People with Mental Health and Substance Use Conditions

Through the practice of using rate-ups, insurers imposed "a fine around somebody with a mental illness." One underwriting manual noted a minimum 25 percent rate-up for individuals with anxiety, nervous disorders or depression. A couple of respondents referenced rate-ups of 25 percent or 50 percent above the standard premium.

> ***"Know that we did underwrite, did rate up, and [there] would be a detriment, a fine around somebody with a mental illness."***
>
> **— INSURANCE EXECUTIVE —**

Exclusionary riders allowed insurers to protect against risk by excluding services that an individual with a preexisting condition was more likely to utilize. According to guidelines one insurer provided to insurance agents, an individual might be offered a plan with a mental health exclusionary rider because of a diagnosis of mild anxiety that is treated with a prescription and monthly counseling. Riders for mental health were often broad, excluding all services related to "all mental health conditions." An actuary said that with mild mental health conditions, including mild depression, individuals might be offered coverage, but "there would be either limits or exclusions placed" on the benefits, including exclusions of "specific drug classes." A similar exclusionary rider on all pharmaceutical agents primarily used for psychiatric conditions was described in another insurer's agent guide.

> ***"I've seen situations where you would have been issued a policy that didn't cover anti-depressants or put a separate deductible on anti-depressants or on depression."***
>
> **— ACTUARY —**

Not all insurers used riders. One insurer used rate-ups instead of riders in recognition that excluding mental health services could drive

up costs for comorbidities because the enrollee would forgo necessary mental health care that would help keep other medical symptoms in check. Another respondent remembered plans that, instead of using an exclusionary rider, placed a "separate deductible on anti-depressants or on [treatment for] depression" for an individual with preexisting depression.

Many Plans Excluded Mental Health and Substance Use Services

According to a recent study, 38 percent of individual market policies available prior to the ACA excluded coverage for mental health and 45 percent excluded coverage for substance use disorders.[22] This was reflected in our interviews and policy review. The director of a behavioral health plan noted that mental health services, including prescription drugs, were not covered in individual market plans in Michigan before the ACA's EHB requirement. An actuary noted that products that had no mental health coverage "sold well." That was likely because of the lower price, as one underwriter noted the insurer's option without mental health coverage "was a lot cheaper plan." As a result, people knowing they needed mental health coverage had to pay a higher standard rate, even before rate-ups were applied through underwriting, by self-selecting a plan with mental health coverage. And, if individuals chose to enroll in a plan without mental health coverage and "they developed [a mental health condition] after they bought a policy, there would be no benefits" for the condition. While some plans offered riders to cover excluded services, such as maternity care riders, an actuary said mental health riders were only offered "in limited situations" and the "rider was so costly people would generally not buy it."

Examples of Mental Health Exclusions

Illinois HMO

MENTAL HEALTH

1. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
2. Services for the treatment of mental illness or mental health conditions.

SUBSTANCE ABUSE

Services for the treatment of substance abuse and chemical dependency, except those described under Alcoholism Services in Section 1: Covered Health Services.

Wisconsin PPO

Health care services and prescription legend drugs provided in the connection with alcoholism, drug abuse and nervous or mental disorders.

Source: Authors' review of individual market policies available prior to ACA

[22] Claxton G, Pollitz K, Semanskee A, and Levitt L, "Would States Eliminate Key Benefits if AHCA Waivers are Enacted?" Kaiser Family Foundation, June 2017, http://files.kff.org/attachment/Issue-Brief-Would-States-Eliminate-Key-Benefits-if-AHCA-Waivers-are-Enacted, (Accessed October 18, 2017).

Insurers Offered the Minimum Necessary to Be Competitive and Meet State Benefit Requirements

Insurers that did offer mental health and substance use coverage did so for two primary reasons: to comply with state benefit requirements and to be competitive in the market. Insurers often found no advantage to offering more than the state mandate, except when marketing to compete with other insurers covering some mental health services.

State benefit requirements were meant to create a floor for coverage, but insurers were unlikely to offer coverage beyond the required minimum. The state of Michigan required some limited substance use disorder coverage.[23] As a result, the director of a behavioral health plan said "only substance use disorder was covered, per state mandate, with dollar limit[s]" in the individual market plans offered in Michigan. Not only did Michigan plans limit substance use coverage to the level required under the mandate, but the director said they also excluded coverage for mental health services. An actuary said, "One of the criticisms of industry is that whatever limit was in state mandate, that became protocol for care." This was seen in a plan offered in California that just met the state's mandate by covering "diagnosis and treatment of severe mental illness (SMI) for adults and children and for diagnosis and treatment of serious emotional disturbances (SED) of children" while excluding all other mental health services.

> ***"We were not trying to exceed or be less generous than competitors in the market. We were looking for plans similar to everybody else in the market and were seeing the same thing with others in the market."***
>
> **— FORMER INSURANCE EXECUTIVE —**

Multiple respondents mentioned there was often one dominant carrier in a market that set the base for benefits. In some instances, the dominant carrier could offer mental health and substance use benefits because they had so many enrollees that "per person cost was lower" and "because they usually had better contracts with providers" so the cost of providing the services was lower.

To compete for customers, plans offered limited mental health and substance use benefits to be able to market their plans as having coverage while limiting their risk. The goal was to design plans that "look better because we say we offer mental illness," but that had limited benefits because, without limits, the actuaries would "price them out of the market." Insurers trying to offer benefits that were comparable to other carriers in the market "were always looking over [their] shoulder at what [their] competitor was doing." A product manager said that, in the states without a parity requirement, the insurer looked at "what the market was offering" and that they were "not trying to exceed or be less generous than competitors in the market."

[23] Mich. Comp. Laws § 500.3425.

A couple respondents noted that they sometimes relied on brokers and agents to tell them what coverage was available in the market and what the agents could sell to individuals. According to one executive, focus groups of agents helped insurers determine that limited mental health benefits were marketable in the individual market; in part, this was because that is what the agents told consumers they needed for protection.

Benefit Limitations Made Coverage Superficial

Limitations in coverage meant that if an individual did make it past underwriting, could afford the premiums and found a plan that offered mental health and substance use services, then the coverage was often insufficient to meet their needs. One recent study found that, of the relatively small share of plans covering substance use disorders, 22 percent limited the coverage to fewer than 30 visits or sessions in a year and 12 percent limited coverage to 12 visits or less.[24] Between various benefit limits and stringent utilization management, many people were not able to access needed care. As one actuary said, "either it wasn't covered or had more limited benefit."

> ***"The most common thing was to offer limited coverage for mental health rather than treat it as an underwriting issue. That was the most effective. Either it wasn't covered or had more limited benefit."***
>
> **— ACTUARY —**

Limits on Services Kept Insurer Risk to a Minimum and Placed Financial Risk on Enrollees

Health insurers limited mental health and substance use in various ways, but perhaps the most common was limits on the amount of services covered, including outpatient visit limits and limits on inpatient days covered. The limits "varied by type of service" and applied to services that were used in mental health and substance use treatment settings, such as a limit on days covered for treatment at an inpatient rehabilitative program or a limit on outpatient counseling visits.

Dollar limits, such as a limited reimbursement amount per visit or even

Examples of Visit Limits for Mental Health and Substance Use Services

- Outpatient and intensive outpatient services are limited to combined total of up to 40 visits over a 2-year period (policy available in Washington)
- Inpatient care limited to 6 days per member per year; outpatient care limited to 6 visits per member per year (policy available in Washington)
- Inpatient care limited to 60 days for non-biologically-based mental health conditions (policy available in Massachusetts)
- Treatment of "substance abuse and dependency" limited to 7 days of confinement per admission, with a lifetime maximum of 4 confinements (policy available in Pennsylvania)

Source: Authors' review of individual market policies available prior to ACA

[24] Claxton et al, "Would States Eliminate Key Benefits if AHCA Waivers are Enacted?"

Examples of Dollar Limits
(Policy Available in Washington)

- Total outpatient benefits paid for treatment of mental or neuropsychiatric conditions limited to $500 per insured per year
- Total benefits paid for inpatient treatment of mental or neuropsychiatric conditions limited to $10,000 during a 24-month period and a lifetime maximum of $30,000
- Total benefits paid for treatment of chemical dependency limited to $10,000 during a 24-month period

Source: Authors' review of individual market policies available prior to ACA

Types of Limits on Mental Health and Substance Use Benefits

Outpatient Visit Limits

Inpatient Day Limits

Dollar Limits

Higher Copayments

Applying Deductible to Mental Health and Substance Use Services

Source: Authors' review of individual market policies available prior to ACA

a lifetime cap, were also used for mental health and substance use services. One actuary noted a $5,000 or $10,000 lifetime limit on mental health coverage was "common."

Some plans limited coverage by imposing higher cost-sharing for mental health and substance use services. One plan in California did not apply the deductible to primary care or specialist visits, but did apply the deductible to outpatient mental health visits that were not for a serious mental illness or severe emotional disturbance of a child (despite a state coverage requirement prohibiting differential cost-sharing).

Condition-Specific Limits Left Many Enrollees Without Necessary Coverage

In addition to limits on types of services, there were also "categorical or diagnosis limitations." A policy offered in Washington defined mental health services to exclude specific diagnosis codes in the Diagnostic and Statistical Manual of Mental Disorders (DSM), a definition that was not likely to be easily understood by applicants or enrollees. Another policy offered in Minnesota defined coverage to include diagnoses included in the DSM "that lead to significant disruption of function in your life."

One respondent said that eating disorders were generally excluded. As a result, medical services would be denied if the insurer determined that treatment was "due to an eating disorder." When eating disorders were not excluded, this respondent said plans would constrain eating disorder coverage in other ways, such as exclusions for residential treatment or limiting coverage to one treatment episode per lifetime. With regards to treatment for a gambling addiction, one respondent said "forget about treatment for that."

Some plans limited substance use treatment services differently than mental health services. A respondent noted that licensed addiction counselors were often excluded from plan provider networks. Some plans would cover one 30-day residential treatment per lifetime for addiction. A former chief legal counsel for an insurer said that the limits on substance use treatment were basically

> *"Addiction was considered a social or moral failure so [the plan would have] one lifetime 30-day residential treatment, period, end of story."*
>
> **— FORMER CEO OF BEHAVIORAL HEALTH PLANS —**

under a theory that "if it wasn't working," then more services would not help. One respondent said limits on substance use treatments were, in part, related to a moral belief that the individual was at fault if treatment was not successful.

Prescription Drug Benefits Discouraged or Excluded Use of Mental Health Drugs

There were significant limits in access to prescription drugs for mental health conditions. Many of these limits were a result of general formulary rules rather than attempts to limit mental health coverage. For example, an actuary noted that there were "a lot of products pre-ACA that provided either generic-only or no prescription benefit at all." One pharmacy benefit consultant did say that while mental health drugs were generally not excluded from the formularies since some could be used for other conditions, they were often put on a higher cost tier.

> *"A lot of products pre-ACA provided either generic-only or no prescription benefit at all. I found a surprising number with no prescription at all when I went over a survey of the most popular products."*
>
> **— ACTUARY —**

However, there were particular tools used by insurers that reduced access to mental health drugs. First, if a plan excluded mental health services, that meant mental health drugs were also generally excluded. Second, underwriting tools were applied to formularies. One pharmacy benefit consultant said exclusionary riders began on medical benefits, "then began to drift into pharma side," resulting in exclusionary riders on drugs. According to one underwriter, if an individual was on a high cost mental health drug, that would play a role in the underwriting determination and might result in increasing the drug deductible.

The pharmacy program was also used for "monitoring on the drug side to then further identify individuals who may not have disclosed mental health conditions up front." A pharmacy benefits director explained that the plan "would maintain tables behind the scenes in pharmacy that would connect to ICD-10 codes associated with mental health conditions."[25] If an individual had a condition that had

[25] ICD-10 is an abbreviation of The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) which is a system health care providers and payers use to classify health diagnoses, symptoms and procedures.

not been disclosed in the application for coverage, the plan would block access to particular drugs or categories of drugs, if allowed under state law.

When Trying to Access Coverage, Stringent Utilization Review Created Barriers or Denied Access to Care

Many people had coverage for mental health and substance use services on paper, but were denied access to covered services by stringent utilization review and medical management. As one respondent said, utilization management "is behind the curtain so doesn't affect marketability." A health plan pharmacist said the insurer he worked for used only one formulary for all plans for administrative simplicity, but then limited access to high-cost drugs. "We had a formulary that had everything on it, and then behind the scenes, per member, we were able to block. That way, it saved a lot of logistical work on our end, rather than having to maintain multiple formularies." When asked if enrollees were sometimes caught off guard when their treatments were denied, a respondent said, "Absolutely."

> ***"We had a formulary that had everything on it, and then behind the scenes, per member, we were able to block."***
>
> **— PHARMACY DIRECTOR —**

Utilization management is used for many covered services, not only mental health and substance use services, and is often based on the ICD billing code. However, there was a sense among some respondents that some insurers used more aggressive utilization management for mental health and substance use. The use of utilization management was not just to ensure the right care was provided, but used for "blocking and tackling" and "to limit access to care." Some plans "always required preauthorization" for mental health services, so enrollees would need to call to get approval even for outpatient counseling. It should be noted that one underwriter said utilization management increased after implementation of the EHB because, prior to that, the plans she worked on had dollar limits on coverage. The utilization management was not necessary to control costs that were already constrained by a dollar limit.

For plans that carved out behavioral health services, the behavioral health plan running the carved-out benefits would handle preauthorization requests. The process could be cumbersome. One respondent who worked for such a plan said, "You'd have a 45-minute phone consultation with the physician, then get authorized or not, then get 5 sessions, then call after 3 to get more."

> ***"You'd have a 45-minute phone consultation with the physician, then get authorized or not, then get 5 sessions, then call after 3 to get more."***
>
> **— FORMER CEO OF BEHAVIORAL HEALTH PLANS —**

The process for approving or denying services was not always spelled out in clear procedures. In some instances, the director of the behavioral health plan would meet with a plan's medical

director to decide whether or not to cover an enrollee's service, and it would be at their discretion to choose whether or not to advocate for coverage. As a result, something such as hospitalization resulting from a self-inflicted injury may or may not have been covered. In other instances, utilization management would be used to determine if the underlying cause of a medical condition was a mental health diagnosis, such as services to treat malnutrition resulting from anorexia. If the underlying condition was determined to be an excluded condition, the plan denied the services.

Prior-Authorization Language Specific to Mental Disorders and Detoxification (from California Plan)

"To be covered, the Administrator must authorize these services and supplies. In an emergency, call "**911**" or contact the Administrator at the telephone number shown on your Health Net ID Card before receiving care."

"If the Administrator does not approve the treatment plan, no further services or supplies will be covered for that condition. However, the Administrator may direct you to community resources where alternative forms of assistance are available."

Source: Authors' review of individual market policies available prior to ACA

> ***"We might not offer plans that offer those types of benefits if we're not forced to, because the costs are so high, and when you're a publicly traded company and you can't meet earnings expectations because of higher than expected losses, it's just the way of the world."***
>
> **— HEALTH PLAN PHARMACIST —**

Flexibility in the Essential Health Benefits Could Mean a Return of Limits and Exclusions in Mental Health and Substance Use Treatment Coverage

The EHB requirement in the ACA changed mental health and substance use treatment coverage in the individual market. The EHB expanded coverage in three ways. First, many plans had to expand the types of mental health and substance use treatment services covered to come in line with the state benchmark, which is most commonly a small group market plan. Second, any dollar value limits were eliminated because dollar value limits are not allowed on EHB. Finally, because EHB regulations required parity, plans had to eliminate visit limits and utilization management procedures that were stricter than those applying to other medical services. Basically, insurers "took what they had listed in the benchmark as their covered services and compared to what [the insurer] listed as covered services…[and] then eliminated limits." If the EHB requirements are weakened or eliminated, many respondents expect insurers to return to old practices of excluding or limiting mental health and substance use treatments.

Carriers Are Likely to Return to Pre-ACA Limitations to Reduce Risk

Some insurance industry experts interviewed said there is now a greater understanding and acceptance of mental health and substance use disorders, and a recognition of the impact of mental health on overall health. However, if insurers are granted greater flexibility, even those that see the value of adequate mental health and substance use disorder coverage would need to limit coverage in order to compete in the market.

Many of the respondents expected insurers would migrate back to pre-ACA benefit designs and utilization management to reduce costs. "I'm scared" was the response of one former CEO of behavioral health plans who expected many of the pre-ACA practices to return. Another executive expects plans "would have actuaries doing deep dives into outlier claims cost," looking into services, including mental health services, that are particularly costly and could be excluded from benefits.

If parity requirements are lost, multiple respondents expect visit limits, dollar limits and higher cost-sharing would return. Coverage could be limited in a variety of ways. Dollar value limits, as well as visit limits, were mentioned by respondents as something that would be at least discussed within insurers. An actuary said, "You would probably see attempts to create more restrictive networks of mental health providers with different coinsurance and out-of-pocket limits applied." Some expect it would be possible that all mental health and substance use services would be excluded by some insurers. A product manager talked about how many individual market plans excluded maternity care and would only cover maternity services through a rider before the ACA and said, "If left to our own devices, we could consider that type of construction for mental health services too, so it would be something people would have to add on or buy up." Once some insurers start to revert back to limited coverage, others will need to follow suit or they will "get all the bad risk and none of the good."

Carriers Want Some Rules on Mental Health and Substance Use Treatment Coverage

While many respondents expected insurers would revert to old practices limiting mental health and substance use coverage, they also expressed a desire for some rules providing a minimum set of benefits. With the EHB standards in effect, "at least [insurers] can look and know where to go." If there were changes to the EHB requirements and state regulators filled gaps, then insurers would know the rules rather than guessing what their competitors would do. But, there was concern that some states might make rules that are not based on medical need. An actuary noted that some states are concerned "about things considered quote 'immoral or illegal'" and that such states may make policy based on biased moral assumptions rather than the medical need to provide treatment.

DISCUSSION

Before the Affordable Care Act, the individual health insurance market was riddled with persistent problems of availability, affordability and adequacy for people with mental health and substance use disorders. People with mental health and substance use conditions were routinely denied coverage. Those that could get coverage faced higher premiums in addition to lower benefits and higher cost-sharing for mental health and substance use conditions—or treatment for these conditions was excluded altogether. Plans also limited access by restricting pharmacy benefits, excluding or limiting mental health and substance use providers from their network and by placing strict limits on the amount of mental health and substance use services covered.

The ACA changed this by remedying persistent discrimination against people with preexisting conditions and requiring coverage of mental health and substance use treatment services in the individual health insurance market. With the regulatory requirements that such coverage be comprehensive and provided at parity with other medical coverage, individuals no longer faced unequal limits on mental health and substance use treatment coverage.

Currently, there is a national debate underway about regulation of health insurers and benefit standards. Under the guise of reducing regulatory burdens, the Executive Branch has enacted regulatory changes that weaken the EHB requirements by giving more flexibility to states and insurers to define and limit services, including mental health and substance use benefits. Further, proposed regulatory changes would significantly expand access to coverage that is fully exempt from the EHB requirements, granting insurers broad flexibility to design benefits that can discriminate against people with preexisting conditions.

While there is broad bipartisan support for the Mental Health Parity and Addiction Equity Act (MHPAEA), a change to regulations could roll back the application of this federal parity law to the individual market. Without strong benefit and parity requirements in the individual market, insurers are likely to turn back to their pre-ACA practices in states that fail to maintain strong EHB and parity requirements. Our interviews suggest insurers would do this out of necessity, in order to compete with insurers that limit coverage for mental health and substance use conditions, setting up a race to the bottom. In an attempt to have low premiums and a healthier risk pool, insurers can be expected to reinstate exclusions, limits and stringent utilization management on mental health and substance use services.

The effects would likely go beyond the individual market. The EHB requirements also apply to the small group health insurance market and the benefit package provided to people covered through the Medicaid expansion. Insurers would also look to other categories that were commonly excluded or limited

before the ACA, such as maternity care and prescription drug coverage, to trim benefits. Some of the prescription drug practices that limited coverage of drugs for mental illness could return, limiting coverage for a large range of prescription drugs.

According to our findings, weaker EHB standards and greater access to coverage exempt from the benefit protections could readily result in insurers moving to previous practices that limit enrollment of people with mental health and substance use disorders and limit access to services. The result would be that people, once again, would be left without access to insurance that meets their mental health care needs.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the time and insights shared by the insurance experts and company representatives we interviewed. We also thank Christine Ferguson and Leverage Global Consulting for their research support, Karen Pollitz and Irvin Muszynski for their thoughtful review and comments, and the National Alliance on Mental Illness for its generous support of this project.

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