Mental Health Treatment: Issues Surrounding Health Insurance Coverage

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Addressing Mental Health/Substance Abuse Needs:  
A Pressing Priority

Prevalence of Mental Illness
• 1 in 5 U.S. adults experience mental illness each year (43.8 million or 18.5%)
• 1 in 25 U.S. adults experience serious mental illness each year (10 million or 4.2%)
• 1 in 5 youth aged 13-18 (21.4%) experiences a severe mental disorder during lifetime; 13% of those 8-15
• 2.6% of U.S. adults are bipolar; 1.1% live with schizophrenia
• 20.2 million U.S. adults experienced a substance use disorder, with 10.2 million (50.5%) having a co-occurring mental illness

Impact of Mental Illness
• 26% homeless suffer mental illness; 46% severe and/or substance abuse
• 20% of state/local prisoners “recent history” of a mental health condition
• 70% of youth in juvenile justice systems have at least one mental health condition

Consequences of Lack of Treatment
• Serious mental illness costs America $193.2 billion in lost earnings per yea
• Mood disorders 3rd most common cause of hospitalization ages 18-44
• Suicide is 10th leading cause of death in the U.S. (3rd for ages 10-24; 2nd for 15-24)
• More than 90% of children who die by suicide have a mental health condition
• An average of 20 veterans die by suicide daily

Inadequate Treatment
• 41% of Americans with mental health condition receive treatment; 62.9% with serious mental illness; half of children 8-15 (50.6%) received treatment they needed
WHY WE NEED ACTIVE ATTORNEYS GENERAL TO PROTECT CONSUMERS IN THE MENTAL HEALTH ARENA

• **Limitations on State Insurance Department oversight:**
  -- Focus on reviewing plans for regulatory compliance and insuring financial stability, not auditing ongoing practices
  -- Most plans are governed by ERISA: “Almost 95% of US companies with at least 5000 employees currently self fund their health benefit plans. . . . Today, the self-funded market, regulated by the Department of Labor and under the protection of the Employer Retirement Income Security Act, now includes nearly 60% of US employers of all sizes.” (www.ajmc.com)

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**Exhibit 10.1**
Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Size, 1999-2013

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<tbody>
<tr>
<td>3-199 Workers</td>
<td>13%</td>
<td>15%</td>
<td>17%</td>
<td>13%</td>
<td>10%</td>
<td>10%</td>
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<td>200-999 Workers</td>
<td>51%</td>
<td>53%</td>
<td>52%</td>
<td>48%</td>
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<td>48%</td>
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<td>1,000-4,999 Workers</td>
<td>62%</td>
<td>69%</td>
<td>66%</td>
<td>66%</td>
<td>71%</td>
<td>72%</td>
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<tr>
<td>5,000 or More Workers</td>
<td>62%</td>
<td>72%</td>
<td>70%</td>
<td>72%</td>
<td>72%</td>
<td>70%</td>
<td>80%</td>
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<td>93%</td>
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<td>ALL FIRMS</td>
<td>44%</td>
<td>49%</td>
<td>49%</td>
<td>49%</td>
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* Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006. Therefore, conventional plan funding status is not included in the averages in this exhibit for 2006. For definitions of Self-Funded and Fully Insured plans, see the introduction to Section 10.

WHY WE NEED ACTIVE ATTORNEYS GENERAL - cont.

- **Limitations under ERISA:**
  -- Complicated (few attorneys understand complexities)
  -- Limited remedies (denied benefits, plus interest; discretionary attorneys fees; no compensatory/punitive damages)
  -- Exhaustion requirement
  -- Deference given to plan administrators (“arbitrary and capricious standard” in interpreting plan documents drafted by insurers)
  -- Unwillingness of mental health patients to sue
WHY WE NEED ACTIVE ATTORNEYS GENERAL - cont.

• *Failure of Free Market in regulation health insurance industry:*

  -- Those who need care do not select health insurance (most selected by employers)
  -- Employers who select health insurance primarily concerned with cost, not coverage
  -- People choose health insurance when they are well, not sick (cost primary factor)
  -- Insurers influenced by stockholders, not insureds
WHY WE NEED ACTIVE ATTORNEYS GENERAL - cont.

• **Limitations on private plaintiff attorneys:**
  -- Individual cases are too expensive to litigate;
  -- Class actions are complicated, time-consuming and risky (insurers avoid the merits by aggressively fighting class certification issues);
  -- Class actions require focusing on common issues that limit considerations of individualized issues;
  -- Because many cutting edge issues, insurance companies have little incentive to settle (few experienced practitioners); Ex. *American Medical Assn. v. UnitedHealthcare* (S.D.N.Y.): filed in 2000, settled in 2010 (only after NYAG opened up investigation); $350 million class settlement; NYAG established FAIR Health Database;
Need to Challenge Insidious Restrictions on Coverage for Mental Health/Substance Abuse

• Parity laws effectively eliminated obvious (numerical) discrimination
• Insurers turned to non-quantitative restrictions (revised Fed. Parity Act)
• Insurers now hiding restrictions in internal guidelines (*public unaware*):
  – Medical necessity and coverage decisions are based on internal policies and guidelines adopted and applied by claims administrators; not disclosed in plan documents or available for easy public scrutiny)
• *Wit v. United Behavioral Health*, Case No. 3:14-cv-02346-JCS (N.D. Cal.)
  - Plaintiffs allege that UBH relies on internal coverage guidelines for mental health and substance abuse services which are inconsistent with generally accepted standards of care; *insureds do not get what they are promised*:
    – UBH’s guidelines require a patient to demonstrate by “compelling evidence” that the requested level of care is necessary to prevent “acute” deterioration of condition; high burden is placed on the patient to justify receiving care
    – Generally accepted standards of care require higher level of treatment unless there is “clear and compelling” evidence that a lower level of care is more appropriate (*i.e.*, the burden of proof is reversed); treatment *not* conditioned on *acute* risks, but long term benefits
Need to Challenge Insidious Coverage Restrictions - cont.

Example of abuses resulting from improper guidelines:

- John Smith admitted for treatment to RTC on 6/18/15; opioid (heroin) addiction, untreated bipolar disorder, high risk of relapse
- 8 failed short-term rehab programs; two prior suicide attempts
- Facility sought approval for 28 days (45 days likely); UBH approved six, requiring ongoing requests for more time
- On 7/9/15, after 3 weeks, UBH denied all further coverage: did “not have extreme health or emotional problems including from coming off of drugs” so “not need 24-hour nursing care”; no discussion of relapse
- UBH’s denial contrary to American Society of Addiction Medicine (“ASAM”) standards:
  - transfer to lower levels of care only when patients “established sufficient skills to safely continue treatment without the immediate risk of relapse, continued use, or other continued problems”;
  - discharge is inappropriate unless “[t]he patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission
Ex. of abuses from coverage denials - cont.

• On 7/10/15, facility noted John still struggling; his “cravings for heroin [had] come back”; his mental health was “still unstable; he is quite manic and still pretty high there”; “frequent thoughts of suicide”

• On 7/13/15, UBH denied urgent appeal: “There are no serious medical or mental health problems. You appear to be doing better. You do not have withdrawal symptoms.”; no discussion of relapse risk

• Contrary to ASAM and other guidelines -- no focus on relapse risk; RTC does not require “serious medical/mental health problems”; and “withdrawal” related to detox, not rehab

• John discharged on 7/13/15; failed out-patient treatment effort; relapsed; died of drug
INADEQUATE MENTAL HEALTH NETWORKS

- Inadequate mental health networks, lead to few options for patients and far higher out-of-pocket costs
  - Patient discovered that her out-of-network psychiatrist was receiving lower reimbursement than husband’s out-of-network psychiatrist;
  - Anthem said had erroneously identified husband’s provider as a General Practitioner rather than a behavioral health provider, so Anthem paid a GP higher than a psychiatrist for therapy;
  - Anthem conceded to Colo. DOI that it used different payment methodologies for behavioral health and medical/surgical providers:
    - For Medical, Anthem uses a “relative value unit” (“RVU”) methodology, based on an approach developed for Medicare;
    - For Behavioral Health, Anthem applies its in-network fee schedule
  - Plaintiff alleges that pricing methodology results in behavioral health providers being paid lower than medical providers resulting in inadequate networks and increased patient costs