Closing the Coverage Gap

Improving Access to Mental Health and Substance-Use Disorder Services

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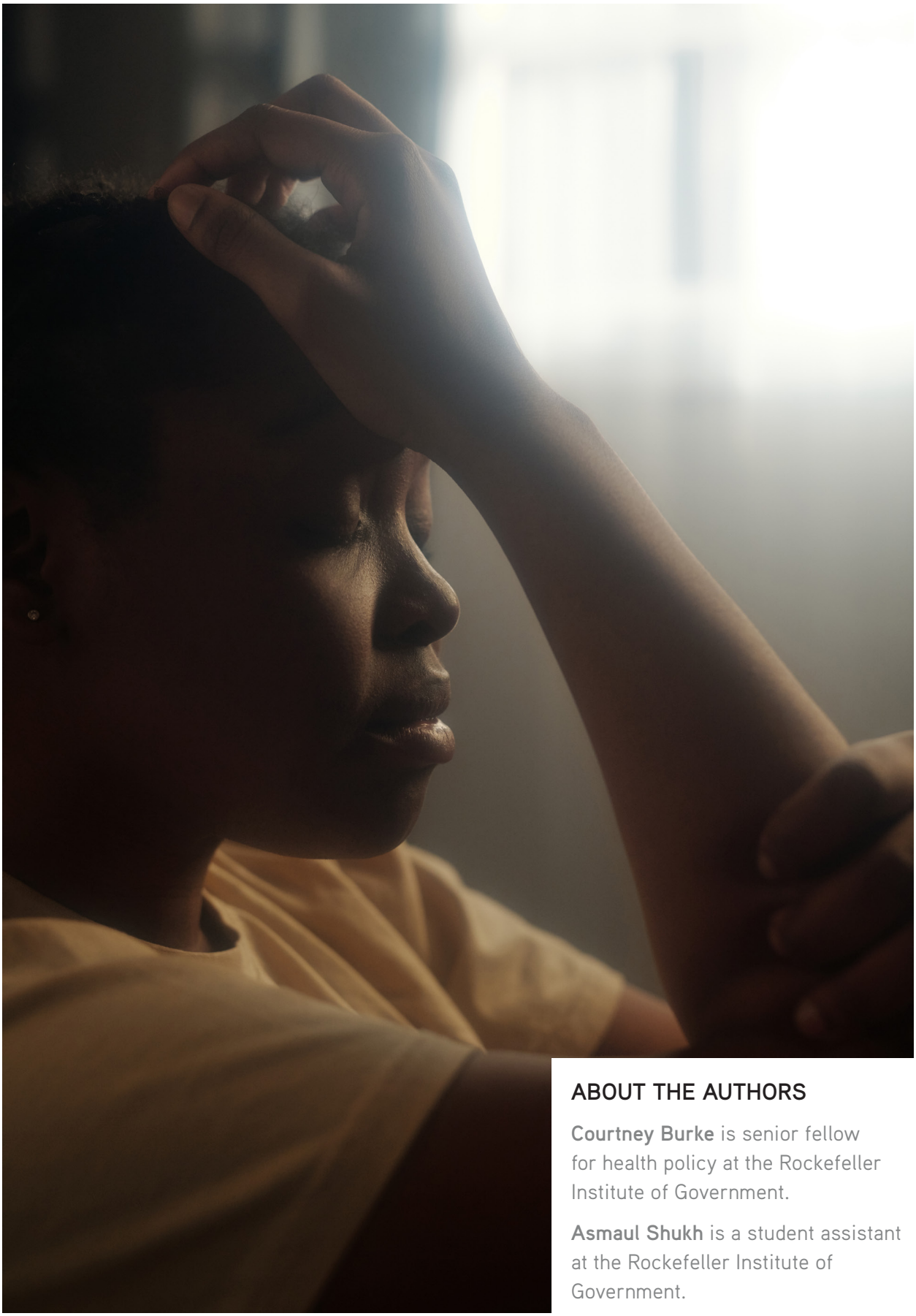

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Closing the Coverage Gap

Executive Summary

Issue

Across the nation, a large number of adults, children, and their loved ones are grappling with substance-use disorders and mental health challenges. Many are people seeking the behavioral health services they need to address these issues, however, can face months or even years of waiting for urgently needed care, during which time their conditions can worsen, leading to preventable and devastating life-altering outcomes, including overdose or suicide.[1, 2] These effects ripple through families and communities, with disparities in access to care further impacting marginalized communities, such as racial and ethnic groups, LGBTQ+ individuals, and people living with disabilities.[3, 4]

Access to behavioral health services is challenged by underfunding the service system, reimbursement rates that may fail to cover the full cost of care, and, at times, constraints imposed by rules and regulations. These systemic issues also contribute to widespread staffing shortages in behavioral health, further reducing the availability of essential services.[5, 6, 7]

While there are multiple factors that contribute to delays in access to substance-use disorder and mental health services, this paper examines barriers arising from insurance-related challenges. It provides examples of existing and proposed policies and initiatives from several states that demonstrate ways to improve access to care through insurance policy reforms. Finally, it provides options and opportunities to improve access to care through both public and private insurance at the state and federal levels.

Summary of Options and Opportunities

The following are some of the options and opportunities identified that the federal government and states can use to improve insurance access and coverage for behavioral health services. Of note, the federal government through the passage of legislation has the ability to set a minimum for standards for a wide variety of programs or policies upon which states can build.

- Enhance enforcement of behavioral health parity laws to ensure equal coverage for mental health and substance-use disorder services with other health services, including for commercial and public plans. States may employ more rigorous monitoring and enforcement measures of insurance companies, including making data and policies publicly available and easily accessible.
- Make behavioral health services more affordable by reducing financial barriers for patients, such as addressing high costs of out-of-network care, high deductible health plans (HDHPs), and gaps in insurance coverage.
- Simplify or eliminate unnecessary administrative barriers, such as pre-authorization requirements that delay care and can result in an unnecessary denial of essential behavioral health services. This also might include implementing a standardized and electronic prior authorization system.
- Enhance the accessibility of behavioral health providers within insurance networks by increasing reimbursement rates and ensuring compliance with network adequacy regulations. Adequate networks increase the likelihood that an individual receives timely care, as services that are out of network, or not covered by insurance, are often cost-prohibitive.
- Educate consumers about their right to appeal a denied claim and equip them with the support necessary to effectively navigate the complaints process, including for plans that are under the oversight of other states.
- Ensure payment from public insurance programs such as Medicaid is adequate to cover the cost of care by raising reimbursement rates or requiring minimum payment levels to providers in instances when a consumer has private insurance.
- Evaluate and identify strategies to mitigate disruptions in care during insurance transitions.

Part 1: The Behavioral Health Crisis

National Scope

In the United States, approximately one in three adults aged 18 or older (84.3 million individuals) experienced a behavioral health condition (defined broadly here as either a mental illness or substance-use disorder) in 2022. Among adolescents aged 12 to 17, one in five (4.8 million individuals) reported having a major depressive episode during the same year, a condition that can increase the risk of suicidal behaviors and the development of substance-use disorders.[8] Substance use disorders significantly affected US residents, contributing to 107,947 overdose deaths in 2022.[9] Furthermore, in 2023, three in ten adults reported having a family member living with opioid use disorder.[10]

New York State

Over one in five adults in New York (3.3 million) reported any mental illness, while over one in six adults (2.8 million) reported substance-use disorder in 2022. Nearly one in five youth aged 12-17 (272,000) experienced at least one major depressive episode (MDE) in the past year, and nearly one in ten youth (132,000) were living with a substance-use disorder in 2022.[11] In New York alone, more than 2.3 million adults with substance-use disorder went untreated. Furthermore, 5 percent of adults with any mental illness were uninsured in 2022.[12]

Populations At Highest Risk for Behavioral Health Disparities

Some populations are exposed to a higher number of behavioral health risk factors than others, including disparities in access to care, making them more vulnerable to the long-lasting impacts of mental health and substance-use disorders.[13]

People living with behavioral health conditions experience a number of barriers to accessing timely services, including transportation, technology access, stigma, and the limited availability of care providers. However, the ability to pay for care is among the biggest challenges.[14]

Overview of Insurance Coverage Issues

Insurance coverage, whether public (e.g., Medicaid, Medicare, the Children's Health Insurance Program—CHIP), or private, is instrumental to helping people access services and support for behavioral health needs by covering the costs of care, they would otherwise be unable to receive. Medicaid, a public insurance program paid for by federal and state governments and is primarily administered by states, plays a particularly important role in paying for behavioral health services, especially for low-income individuals. In 2020, nearly 40 percent of Medicaid enrollees were diagnosed with a mental health or substance-use disorder.[15] Most Americans have commercial health insurance as many states have contracted with private insurance plans to administer Medicaid services, underscoring the important role commercial plans also play in access to behavioral health services.[16]

However, coverage of behavioral health services remains a significant challenge. Despite the passage of parity laws, such as the federal Mental Health Parity and Addiction Equity (MHPAEA) Act of 2008,[17] which requires more equitable coverage of behavioral health services relative to other health services, insurance plans still impose restrictions by putting in place policies governing conditions for coverage that can cause administrative delays in or deny care (such as prior authorization).[18] These policies create challenges for care providers related to securing adequate and timely reimbursement for services.[19]

PART 2: Insurance Obstacles, Examples of How Government Policies Are Addressing Barriers, Opportunities

Insurance Eligibility

Obtaining insurance coverage is a first step in improving access to behavioral health services. If a person cannot afford to pay for private insurance, they may be eligible for a public insurance program such as Medicaid, which is designed to help low-income individuals access healthcare, Medicare, which provides access to healthcare for persons over 65 and certain people with disabilities, or other programs that provide financial assistance in some states. But not all people are eligible for public health insurance, or the financial support available to purchase insurance. In 2023, an estimated 921,200 New Yorkers were uninsured.[20] For example, under federal programs, undocumented noncitizens only qualify for Emergency Medicaid, which limits coverage to urgent, life-threatening situations, and excludes coverage for preventive and primary care services.[21, 22] Another way access to services can be hindered is when there are unexpected gaps in insurance coverage. This can happen with private health insurance when an individual changes jobs or loses their employer-sponsored coverage and may not be able to afford a stopgap insurance program known as COBRA (named after the Consolidated Omnibus Benefits Reconciliation Act).[23] With COBRA, a potential recipient of the program's benefit must pay the full premium for their health insurance (part of which would have been previously covered by their former employer). An individual on Medicaid might also lose coverage because of a change in income, thus causing interruptions in access to behavioral health services.[24]

It is also well documented that individuals living with behavioral health conditions, substance-use disorder, or serious mental illness are more vulnerable to insurance instability.[25] If there is a need to transition to Medicaid, the application process is rigorous and can take months. During this time, individuals who need care may be unsure of their eligibility for coverage and are dissuaded from accessing care due to concerns about their ability to cover the cost.

Another example of an insurance eligibility gap is the federal Medicaid "inmate exclusion" policy. The policy limits Medicaid coverage for people who are incarcerated.[26] This leads to unnecessary interruptions in care when people who were formerly incarcerated transition back into the community.

Examples of Strategies to Address Barriers to Insurance Eligibility

Despite barriers to accessing both public and private insurance, there are ways for states to provide coverage to more people who may need behavioral health services. For example, states can choose to provide health benefits under Medicaid to certain undocumented noncitizens by being granted a federal waiver or by paying with state-only Medicaid funds. This is true in at least six states, which offer limited health coverage for uninsured children regardless of status, including California, New York, and Illinois and at least 18 states guarantee prenatal care to all persons regardless of immigration status.[27]

In 2024, New York State expanded access to insurance coverage under the Medicaid program to include undocumented noncitizens aged 65 and older at certain income limits.[28] The expansion allows this population to access comprehensive health benefits such as routine doctor visits, screenings, lab tests, and prescriptions. Noncitizens in states such as New York may also become eligible for public insurance by establishing federal status as Permanently Residing Under Color of Law (PROCUL).[29]

To address barriers to access to insurance coverage, through a federal rule change in November 2024, insurance coverage was expanded to the Deferred Action Childhood Arrivals (DACA) population allowing them to enroll in Affordable Care Act (ACA) plans.[30] DACA individuals also may qualify for premium subsidies if they meet certain income requirements. This rule change could extend insurance to around 100,000 uninsured DACA recipients out of the estimated half-million DACA participants in the US. However, 19 states, including Kansas and North Dakota, are legally challenging the rule, arguing that expanding coverage to DACA recipients places additional administrative and financial burdens on states. The court case remains ongoing, and a ruling may impact DACA recipients' access to health insurance.[31]

New York City established a healthcare access program for city residents who are ineligible or cannot afford health insurance, regardless of immigration status. Through the NYC Care program, residents can access care similar to those who are insured, through the public healthcare system, NYC Health + Hospitals.[32]

As it relates to persons seeking care at an Institute for Mental Disease (IMD), many states have sought to circumvent this rule by applying for Medicaid waivers. An IMD is defined as hospital, nursing facility, or other institution of more 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.[33] As noted in a 2023 issue brief from the Congressional Budget Office citing the Kaiser Family Foundation, as of September 26, 2023, 35 states had approved Section 1115 waivers allowing them to receive federal Medicaid funds for SUD services in IMDs and 11 states had an approved waiver for mental health services. At that time, six states had pending waivers for SUD services, and seven states had pending waivers for mental health services.[34]

To reduce disruptions in coverage caused by interruptions in private insurance coverage due to the loss of a job, the federal government has attempted to make

COBRA more affordable by allowing certain individuals to be eligible for a refundable Federal income tax credit that can help with qualified monthly premium payments. This assistance is known as The Health Coverage Tax Credit (HCTC) and can be used to pay for specified types of health insurance coverage (including COBRA continuation coverage).[35] To reduce gaps in coverage for people using public health insurance, some states have used policies that suspend, rather than terminate, eligibility for Medicaid to ensure smoother transitions and reduce coverage gaps. This will be required of all states in 2026 in accordance with the 2024 Consolidated Appropriations Act.[36]

The Centers for Medicare and Medicaid Services has also offered a new Section 1115 demonstration opportunity to support community reentry for people who are incarcerated.[37] The demonstration permits a partial waiver of the "inmate exclusion" policy to help facilitate reentry services and disruptions in care. States also have the option to expand their Medicaid programs to cover all people within a household based on income, but not all states have done this.[38]

Opportunities to Address Barriers to Insurance Eligibility

As shown in the examples above, state and federal policymakers can address the lack of access to both public and private insurance in a variety of ways. One way is to expand Medicaid eligibility for populations that are not eligible for comprehensive health insurance. As noted above, applying for federal Medicaid waivers to cover populations that have typically experienced a lack of access to care such as those in an Institute for Mental Disease, has helped states provide better access to behavioral health services.[39, 40]

In addition, policymakers can also expand coverage to qualify based on income alone and to designated populations that did not previously have access to services, such as the federal government's recent expansion of insurance eligibility to certain populations (e.g. DACA, or undocumented noncitizens over the age of 65 in New York State). It is worth noting that some of these policies could be subject to change depending on the policy leaning of state or federal government officials.

Last, policymakers may consider the vulnerability of populations at high need/high risk of insurance disruptions and streamline eligibility and enrollment in such circumstances, including taking advantage of Section 1115 waiver flexibilities, like the CMS demonstration project for people who are transitioning out of the carceral system.

Behavioral Health Parity

Historically, private insurance has not covered behavioral health services equal to that of other health benefits.[41] This means that a person with insurance could not access behavioral health services on par with other health services, and/or are faced with further administrative challenges that could result in negative behavioral health outcomes.

Examples of Efforts to Address Insurance Parity

In 2006, New York State enacted legislation, referred to as Timothy's Law, to improve parity in access to insurance. This law requires that insurers, "provide broad-based coverage for the diagnosis and treatment of behavioral health disorders at least equal to the coverage provided for other health conditions." It also covers at least 30 days of inpatient care and 20 outpatient care visits per year. It is important to note that not all behavioral health diagnoses are included under this requirement so it would be possible for New York State to expand Timothy's Law to further improve parity for behavioral health conditions, such as post-traumatic stress disorder (PTSD).

As noted earlier, to reduce disparities between behavioral health and other healthcare services and improve access, Congress then passed The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). This Act requires health plans to provide comparable benefits for behavioral health conditions compared with medical and surgical benefits. However, some managed care organizations have repeatedly failed to demonstrate compliance. From 2018–20, New York State managed care organizations were issued 95 citations for behavioral health parity violations.[42]

Building on the MHPAEA, in 2014, the Affordable Care Act required all new small group and individual market plans to cover 10 Essential Health Benefit categories, including mental health and substance-use disorder services, and a requirement for coverage of these services to be on par with other health services.[43] MHPAEA was updated in 2024. According to the new MHPEA regulations, all relevant group health plans must maintain equality between behavioral health and other benefits.[44] The recent changes eliminated previous opt-out options for requirements under MHPAEA for specific groups, including those for self-funded nonfederal government plans, demonstrating that MHPAEA protections could have wider application to more populations. These regulations also mandated that plans must compare non-quantitative treatment limitations (NQTLs), discussed in further detail below, to guarantee behavioral health benefits are not more limited than other benefits, aiming to bridge gaps in access to services and lessen disparities.[45]

California has been active in enforcing behavioral health parity laws. Under MHPAEA's provisions, the state's Department of Managed Health Care (DMHC) recently required seven health plans to recalculate cost sharing on the part of the consumer (the amount of the cost the consumer covers) for behavioral health services after it was discovered that the plans had improperly applied cost sharing for behavioral health services, differing from those for other health services. This resulted in reimbursements totaling $517,375 to enrollees. There are two other notable enforcements involving MHPAEA violations in California. One involved an insurance plan that failed to implement MHPAEA-compliant cost sharing, and another concerned a wrongful denial of residential behavioral health treatment at parity. Each case resulted in the insurance plans being fined $20,000 and a requirement to submit corrective action plans.[46]

Similarly, New York has passed legislation to protect people from surprise bills when they are treated by an out-of-network provider at a participating hospital or ambulatory surgery center in their health plan's network.[47] Another example of a

state that is enforcing parity rules is New Jersey. The state has sought to follow the federal No Surprises Act, which was passed in 2020 by Congress as part of the 2021 Consolidated Appropriations bill, and bans balance billing (or surprise billing) for most emergency and certain nonemergency services, ensuring that patients are not surprised by out-of-network charges when they are treated at in-network facilities.[48] Healthcare providers in New Jersey must give clear notices about billing protections, outlining patients' rights and the steps to take if they believe their protections have been violated.[49] New Jersey's policies are further reinforced by the Consumer Connections programs, which help expand peer workforce development and advocate for equitable access to behavioral health services. These programs ensure that the state's behavioral health parity laws are enforced and that individuals receive fair access to care.[50]

Opportunities to Address Insurance Access and Parity

As shown in New York, California, and New Jersey, states have opportunities to improve parity further by specifying what parity entails, requiring parity in payment for certain types of services, and enforcing existing parity-related measures. The parity rules that states develop can also be applied to both in-person and telehealth services. States have the added opportunity to expand parity for more types of behavioral health services. They can expand who can have access, what is reimbursed, where the care can be provided, and how much providers are reimbursed—all with the goal of improving insurance coverage and access to behavioral health services on par with other health services.

Affordability

Healthcare premiums have grown exponentially through the years. In 1988, healthcare premiums were on average 7.9 percent of compensation compared with 17.7 percent in 2019, with substantial inequalities by race and ethnicity, largely among Black and Hispanic households, which tend to end up paying an even higher percentage.[51]

Coinsurance, co-payments, and deductibles, further restrict access to behavioral health services, particularly for individuals with lower household incomes.[52] High-deductible health plans HDHP), a type of health insurance plan with higher initial out-of-pocket costs and lower premiums than traditional health plans, are becoming more common. Consumers with HDHPs now account for 30 percent of covered workers.[53] In 2023, the median annual deductible for HDHPs was $2,500 whereas some other plans do not have a deductible requirement, but a higher premium.[54] Broader increases in the cost of living further severely limit the ability of people with high deductibles to access nonemergency care, resulting in unmet needs and adverse health outcomes.[55]

Out-of-network costs are also a major barrier to behavioral health services, according to the National Survey on Drug Use and Health. Nearly one in seven behavioral health clinician office visits are out-of-network,[56] and the national average cost of a 60-minute psychotherapy visit with commercial out-of-network providers is 130 percent higher than that with in-network providers.

In addition, when an individual receiving behavioral health services changes their enrollment in a health plan, often due to a change in employer, their existing behavioral health therapist may become out of network. If they can't pay out of pocket because of the affordability, they must stop seeing the provider they have built trust with, disrupting a working therapeutic relationship. It is well understood that a strong therapeutic relationship is the main contributor to treatment success.[57]

Examples of Efforts to Address Insurance Affordability

To address the affordability of health plans for those ineligible for Medicaid, New York City offers access to alternative health plans with financial assistance.[58] New York State also proposed regulations that would require plans to cover out-of-network providers at in-network costs to plan members should they not be able to offer adequate services within their network.[59]

New York State has also passed laws prohibiting plans under their oversight from imposing copayments or coinsurance under certain circumstances.[60] For example, plans that provide coverage for treatment at an opioid treatment program may not impose a co-payment during treatment.

State initiatives aimed at improving price transparency can potentially help highlight differences in price for any services where a consumer has a preplanned choice in accessing services. States have attempted to bring attention to the issues of price differences for certain services by creating what are known as all-payer claims databases. As of 2024, 18 states, including New York, have implemented all-payer claims databases (APCDs) through legislation, requiring insurers, including Medicare, Medicaid, and commercial insurers, to disclose claims data and allow state consumers to compare price data.[61]

But price transparency does not always solve barriers for consumers. The number of "shoppable" services (i.e., those service prices that a consumer can view ahead of time and choose based on price) may be limited.[62] Viewing and choosing services based on price ahead of needing a service also requires that a consumer doesn't need the service urgently, that they understand how to correctly compare prices, and that they have the time and resources to conduct such comparisons. Finally, although price transparency is designed to create choice, services may still be so costly that they may prohibit access.

Opportunities to Address Insurance Affordability

Price transparency is clearly not a panacea for solving the affordability challenges for consumers attempting to access behavioral health services. Other state efforts that may have more impact on affordability might include limiting out-of-pocket and cost-sharing burdens on consumers seeking behavioral health benefits. A second strategy states might use to address affordability issues for consumers might be reducing reliance on HDHPs or providing financial support to alleviate consumer barriers if they do have an HDHP. State policymakers also could consider that reducing the financial burden on patients is interrelated with their rate of usage and strive to find additional ways to alleviate cost barriers to consumers.[63]

Non-Quantitative Treatment Limitations (NQTL)—(e.g., prior authorization, preservice notification requirements

Non-quantitative treatment limitations (NQTLs), which are defined as limits on the scope or duration of treatment benefits that are not based on numbers and can be arbitrarily determined by an insurance company, can hinder access to essential care. Under the Mental Health Parity and Addiction Equity Act (MHPAEA), behavioral health benefits cannot be subject to NQTLs that are stricter than those applied to other benefits. Examples of NQTL can include prior authorization requirements, preapproval needs, and step therapy guidelines are all types of NQTLs.[64]

The 2024 revised MHPAEA rules enhance these safeguards, ensuring that NQTLs are given equal scrutiny for both behavioral health and other benefits, aiming to decrease disparities in access to care. In particular, the updated regulations stress the importance of plans and providers gathering and analyzing data on the effects of NQTLs and making necessary changes if data indicates significant discrepancies in access to behavioral health services compared with other benefits. These regulations also strengthen measures to guarantee adherence, placing emphasis on eradicating biased elements in the development and implementation of NQTLs.[65]

These barriers are described below:

Prior Authorization

Prior authorization is a process that requires health providers to seek approval from insurers before providing certain tests, services, procedures, or medications. While it aims to contain health expenditures and reduce wasteful treatments, prior authorization can impact access to care due to the time required for the approval process and the time it may take to find alternate care options when services are denied.[66] Further, prior authorization can unnecessarily reallocate the time and expertise of direct care professionals away from providing services and into administrative roles that oversee prior authorization.[67, 68] According to the Kaiser Family Foundation, 7.4 percent, or 3.4 million prior authorization requests to Medicare Advantage were denied in 2022. In a 2022 survey of over 1,000 physicians, one out of three respondents reported that prior authorization led to a serious adverse event, and 46 percent reported that it resulted in unnecessary urgent or emergency care.[69]

Fail-First Protocols

Insurers can also impede access to certain types of behavioral health services by using what are called "fail-first" policies.[70] These policies allow health insurers to request or require patients to demonstrate unsuccessful treatment on one or more insurer-preferred medications or services before they receive coverage for the medication or services that their physician recommends. It is used by insurers, in part, to control costs.[71] This policy, as well as the financial burden of paying for multiple steps or types of services, can increase a consumer's total spending and thus potentially limit their future utilization of behavioral health services.

Examples of Efforts to Address Barriers to NQTL

Efforts to improve access to behavioral health services by reducing NQTLs like prior authorization have been ongoing in New York State. For example, new laws were passed in 2019 that prohibit prior authorization by insurance companies for minors entering inpatient psychiatric treatment.[72] The laws also prohibit concurrent utilization review during the initial 14 days of treatment and prohibit insurers from requiring prior authorization for individuals to receive medication-assisted treatment (MAT) for substance-use disorders (SUDs). New York State also requires the approval of behavioral health medical necessity criteria for plans under their oversight. New York State has also tested Medicaid-managed care for NQTLs added or clarified in the 2024 MHPAEA.

To help individuals navigate administrative obstacles, like NQTLs, New York State established a program specifically designed to educate and assist New Yorkers in accessing treatment and insurance coverage for behavioral health services, called the Community Health Access to Addiction and Mental Healthcare Project (CHAMP).[73] The New York State Attorney General's Office also provides a healthcare helpline to assist with these efforts for all services.[74]

In response to concerns about the risks associated with fail first—or Step Therapy—New York State enacted legislation (A02834) in 2016, which amends the state's insurance law and public health law to provide increased protections for patients subjected to Step Therapy protocols.[75] Key provisions include expedited review processes; evidence-based criteria for use in step therapy; step therapy override determinations; and patient and provider protection that prevents a repeat of step therapy protocols.[76] And, to address issues with prior authorization, the state issued guidelines that indicate Medicaid Managed Care Plans must handle prior authorization requests in a standardized way.[77]

California has made progress in eliminating obstacles to receiving behavioral health services through the Department of Managed Health Care's (DMHC) enforcement of the Knox-Keene Health Care Service Plan Act. The Act was established in 1975 to govern health maintenance organizations (HMOs) in order to better guarantee accessible, prompt, and quality healthcare for participants. Recent investigations have found and rectified violations of the Knox-Keene Act, like delays in utilization management decisions and failures to meet appointment availability standards.[78] Under Knox-Keene, the DMHC requires health plans to enhance their guidelines regarding non-quantitative treatment limitations (NQTLs) such as prior authorization, ensuring they are enforced with the same strictness as for physical health services. Furthermore, State Senate Bills 855 and 221 were enacted to mandate timely access to follow-up behavioral health appointments and guarantee the availability of behavioral health services without unnecessary administrative obstacles beginning on July 1, 2022. These measures reflect California's efforts to uphold parity as mandated by the Mental Health Parity and Addiction Equity Act (MHPAEA).[79]

Texas has likewise implemented significant reforms to address non-quantitative treatment limitations (NQTLs) in Medicaid and CHIP programs. The state eliminated

strict limits on behavioral health services, such as residential treatment and counseling, allowing for additional services based on medical necessity. Texas Medicaid's Managed Care Organizations (MCOs) assess NQTLs like prior authorization, medical necessity, and concurrent review to ensure compliance with behavioral health parity laws. These efforts have helped improve access to necessary care without restrictive administrative barriers.[80]

As part of Act 146 of 2022, Pennsylvania introduced a state-administered Independent External Review Process starting on January 1, 2024, allowing Pennsylvanians to challenge denied claims for health services, including behavioral health services. The Pennsylvania Insurance Department (PID), along with CODE PA, developed an online platform where consumers can file these appeals without cost. This external review process applies to commercial insurance policies and is designed to ensure that non-quantitative treatment limitations (NQTLs), like claim denials, are addressed efficiently and fairly.[81, 82]

The process empowers consumers by offering a certified independent review organization to assess the case and medical records. If the review finds in favor of the consumer, the insurer is required to cover the disputed service or treatment. Most appeals are resolved within 60 days, creating a faster pathway for access to necessary healthcare services.[83]

The launch of this new review system reflects Pennsylvania's attempt at enforcing behavioral health parity and removing unnecessary barriers to care, such as prior authorizations and claim denials, that disproportionately impact those seeking behavioral health services. The Transparency in Coverage Report released by the Pennsylvania Insurance Department (PID) found that a significant number of appealed claim denials were overturned, highlighting the importance of this new process for reducing NQTLs.[84, 85]

In 2024, Pennsylvania took a significant step to help consumers challenge denied health insurance claims by launching a state-administered independent appeal process. This process, overseen by the PID, allows Pennsylvanians to submit an appeal for an Independent External Review if they believe their insurer has wrongly denied coverage for a medical service, treatment, or benefit. This review system empowers consumers by offering an independent review completed by certified professionals, and if the review is in favor of the consumer, the health plan is required to cover the service.

As of January 2024, under Act 146 the Pennsylvania Insurance Commissioner established state-specific standards that shifted the external review process from federal oversight to state control, enhancing Pennsylvania's ability to ensure fair treatment of policyholders. The new website, developed by the Commonwealth Office of Digital Experience (CODE PA), streamlines this appeal process, making it more accessible and transparent for consumers.[86, 87]

Opportunities Improve to NQTL

State policymakers could consider eliminating or lowering restrictive prior authorizations by adopting a state's own standardized prior authorization methods

and electronic prior authorization. Indeed, many states have already passed legislation that is designed to streamline how prior authorization works so it is less burdensome for consumers and providers to navigate.[88]

Insurers claim that care denials can sometimes happen as a result of consumers not using the correct terminology or following processes correctly. But navigating prior approval should not be so difficult or require consumers to learn specialized knowledge just to obtain health services. States can use independent reviewers to intervene more quickly to resolve disputes when claims are denied. States could also lessen the likelihood of denials by providing information for consumers or requiring publicly available, simplified, and streamlined appeal processes.

When it comes to step therapy, states have the option to look to evidence-based practices and require compliance with those practices therefore averting the need for step therapy in the first place. States might also look for ways to minimize the use of step therapy when consumers may already have gone through some type of utilization management practice that already required some level of review by the insurer.

Barriers Resulting from Inadequate Provider Networks

Reimbursement Is Inadequate to Cover the Cost of Care

One cause of network inadequacy can be the low levels of reimbursement for behavioral health providers. Without adequate provider networks, consumers can experience difficulties finding available appointments with in-network doctors and behavioral health professionals.[89] The inadequacy of insurance networks for behavioral health is exacerbated by the fact that many psychiatrists cannot always accept insurance plans,[90] because of low reimbursement. In a 2017 comparison of reimbursement between primary care and behavioral health, primary care reimbursements were higher than behavioral reimbursements by 23.8 percent.

Narrow Networks

The number of in-network providers and facilities that are geographically accessible in a health plan can also make a difference in access to behavioral health services. A narrow network can result in behavioral health patients experiencing difficulties securing appointments with an in-network provider and it may force them to go out-of-network. According to a Kaiser Family Foundation (KFF) Survey of Consumer Experiences with Health Insurance in 2023, 33 percent of Medicaid enrollees reported that they could not secure an appointment with an in-network doctor.[91] Out-of-network use for all behavioral health clinician office visits (13.4 percent) was 3.5 times higher than medical/surgical treatment (3.8 percent).[92] In New York State, 46.6 percent of those with commercial health plans utilized out-of-network providers or facilities for their behavioral healthcare, exemplifying the severe issue of network inadequacy.[93]

Inaccurate Directories of Providers/Ghost Networks

A third issue related to network access and adequacy is inaccuracies in health provider directories. Research shows that when consumers did not have up-to-date provider information and erroneously met with out-of-network providers they incurred higher costs than necessary.[94, 95] Ghost networks—generally defined as providers who are not reachable, not accepting new patients, or not in-network even though they are listed as in-network providers—also pose challenges to accessing care. According to the US Senate Committee on Finance, over 80 percent of mental health providers were unsubstantiated network providers after investigating 12 different Medicare Advantage plans across six states.[96] Similarly, the New York State Attorney General's office reported, after conducting a statewide secret shopper survey of 13 health plans, that 86 percent of the mental health providers listed were unreachable, not accepting new patients, or not in-network.[97]

Examples of Efforts to Address Inadequate Network Issues

Federal policies to address insurance access to behavioral health have focused on methods to improve network adequacy. The federal Affordable Care Act (ACA) Marketplace plans are mandated to establish quantitative time and distance standards for their Qualified Health Plan (QHP) network adequacy. This means that these plans must meet specific measurable criteria regarding how far and how long a member should travel or wait to receive care from providers within the plan's network.[98] Medicaid and Children's Health Insurance Program (CHIP) are required to set national maximum standards for certain appointment wait times. The 2021 No Surprises Act mandates that commercial health plans update provider directories every 90 days and also aims to protect consumers from seeing erroneously out-of-network providers and paying for surprise bills.[99]

State policies related to network adequacy have utilized various network standards such as provider-to-enrollee ratios or requiring a minimum number of providers, limiting wait times for an appointment, and minimizing travel time.[100] Twenty-four states have adopted a time-distance standard for Medicaid managed care behavioral health networks while 19 states, including New York, have mandated appointment availability within the network.

In Pennsylvania, when deficiencies are identified, such as a lack of providers in certain regions, MCOs are required to take corrective actions, which may include recruitment of new providers or submission of plans to bridge network gaps. The state also employs access measures such as geographical standards, and quantitative measures for behavioral health services by requiring a minimum of two providers for all state plan services except crisis intervention services, for which at least one provider must be available.[101]

New York, like many other states, has created a regulatory framework and standards for network adequacy.[102] New York proposed regulations mandating that "A MCO shall ensure that its network has adequate capacity and availability of healthcare providers of behavioral health services to offer enrollees appointments within: (1) 10 business

days for an initial appointment with an outpatient facility or clinic; (2) 10 business days for an initial appointment with a healthcare professional who is not employed by or contracted with an outpatient facility or clinic; and (3) seven days for an appointment following a discharge from a hospital or an emergency room visit."[103, 104]

In addition, in New York, for commercial non-MCO plans, the following network adequacy standards are required: 30-minute or 30-mile time and distance standard for other providers that are not primary care providers; two behavioral health providers at minimum per county; and, individual providers, outpatient facilities, and inpatient facilities are required within a plan's behavioral health network.[105]

In addition to efforts by the current and previous governors and the New York State legislature, the attorney general of New York State recently sought to examine (for the purpose of improving enforcement) the compliance of private insurers with establishing adequate networks of providers.[106] The lack of adequate networks is in part impacted by a national shortage of behavioral health professionals, such as psychiatrists.[107] The state has also recently turned to enforcing and funding parity in care. The 2024 state budget required insurers to pay for state-licensed outpatient behavioral health services at least at the Medicaid rate with $84 million in investments tied to this proposal.[108]

In California, there have been new rules to limit the potential for narrow networks. These have included stricter standards for network adequacy, including requirements for appointment wait times, provider numbers, and accuracy of provider lists. In addition, insurers must notify consumers if any of their clinicians are not in-network, aiming to address the issue of unexpected bills for out-of-network services. The state Department of Insurance (DOI) conducts periodic checks and responds to consumer complaints to ensure compliance with these new standards.[109]

Opportunities to Address Inadequate Networks

For consumers who access behavioral health services through Medicaid, state policymakers could consider increasing Medicaid reimbursement rates for behavioral health services to increase the number of participating providers. States could also compare how their payment for behavioral health services ranks against other states' payments and attempt to benchmark rates to similar states. In addition, states have the option to ensure network adequacy by stricter monitoring of compliance with adequacy requirements.

Barriers Posed by Inadequate Reimbursement Rates

Providers have the option to participate in an insurance network. However, some insurance entities may pay those professionals more or less, potentially impacting their ability to be part of an insurer's network. A 2022 report from the Government Accounting Office noted that adequate reimbursement was a major barrier to participating in the provision of service delivery for patients with behavioral health needs.[110] A 2019 Health Affairs article noted that adults with psychological distress reported greater difficulty accessing healthcare relative to those without such distress, regardless of insurance source because of limited provider participation.[111]

Examples of Efforts to Address Provider Reimbursement Rates and Provider Participation in Insurance Plans

The Affordable Care Act (ACA) temporarily increased Medicaid fees to Medicare levels in 2013 and 2014, aiming to improve access to behavioral health services by making Medicaid more attractive to physicians. This increase led to a modest improvement in appointment availability for Medicaid enrollees.

Despite the federal funding ending in 2014, California chose to maintain these higher fees using state funds to ensure continued access to behavioral health services. This decision underscores the importance of adequate reimbursement rates in enhancing healthcare access and demonstrates California's commitment to supporting behavioral health services through proactive state-level policies.[112] More recently, California has looked at ways to enhance access to behavioral health services through Medi-Cal provider rate increases.[113] California has done this by enacting several legislative measures aimed at increasing Medi-Cal (the nickname for the state's Medicaid program) provider reimbursement rates. In 2023, as part of the budget-making process, the California legislature and the governor agreed to establish a Managed Care Organization (MCO) Provider Tax to fund these increases from 2023 to 2026. The measure was then recently solidified through Proposition 35, which passed in November 2024.[114] This strategic move targets a broad spectrum of services, including primary care, obstetrics, and behavioral health services, with the goal of encouraging greater provider participation in the Medi-Cal program.

Effective January 1, 2024, California implemented the first phase of targeted rate increases, directly enhancing payments for primary care, obstetric, and non-specialty behavioral health services. These changes ensure that rates for targeted services are no less than 87.5 percent of the Medicare rate, significantly reducing the payment gap between Medicaid and other insurance types. This adjustment is crucial for behavioral health providers who have historically been compensated at lower rates,[115] which can deter them from accepting Medicaid patients.

For 2025 and 2026, additional rate increases are planned for emergency medical services, reproductive health, community health services, and more. Some of these future investments are contingent on the continuation of funding mechanisms like the MCO tax, emphasizing the state's commitment to sustainable healthcare funding. By boosting reimbursement rates, California aims to improve access to behavioral health services by making Medicaid enrollment more attractive to providers. This policy change, which enables more funding, is expected to address one of the significant barriers to behavioral healthcare, ensuring that vulnerable populations have better access to necessary services.[116]

In 2023 and 2024, Pennsylvania, along with many other states, implemented significant Medicaid rate increases for behavioral health providers. These increases have been part of a broader national trend aimed at addressing the ongoing workforce shortages and inflationary pressures faced by healthcare providers. States like Pennsylvania have focused on increasing rates for specific types of providers, including substance-use disorder (SUD) service providers and applied behavioral analysis (ABA) providers, as

part of efforts to retain behavioral health professionals and expand service availability. These adjustments are designed to bring reimbursement rates closer to or on par with Medicare levels, ensuring that Medicaid beneficiaries receive comparable access to essential behavioral health services.[117, 118]

State-level efforts to expand funding for behavioral health services include a 2024 law that was passed in Florida that allows hospitals that partner with a university school of medicine to be designated as a behavioral health teaching hospital if they meet certain criteria and it establishes a scholarship and grants program for students enrolled in educational programs at behavioral health teaching hospitals.[119] And in 2024, New York State passed legislation requiring commercial insurers to reimburse providers at the same rate as Medicaid, which is typically higher, therefore increasing the likelihood that providers would provide behavioral health services.[120]

Opportunities to Improve Reimbursement Rates

As demonstrated by the numerous examples above, there are many ways states can improve reimbursement rates. They can do so by paying more to behavioral health providers via the state's Medicaid program. They might also put in place requirements for commercial insurers to pay a certain minimum amount, such as was done in New York, or create incentives like grants and scholarships.

Denials as Barriers to Obtaining and Paying for Care

Denial of Care

When coverage is denied in the prior authorization process, consumers can appeal. However, the appeal process often demands significant time from both care providers and consumers, causing delays in access to care. The consumer may have to traverse multiple appeals processes if the service was delivered in a state that is different than where that person resides. Additionally, it diverts care professionals from providing direct services, forcing them to navigate the administrative complexities of the appeal process.

Denial of Payment for Services Already Provided

Another way that insurance denials may negatively impact access to behavioral health is when insurers determine that a service is not eligible for payment after it is delivered. Responsibility for paying the denied claim then falls on the provider or consumer to pay. Denied claims are more common in employer-sponsored (21 percent) and marketplace insurance (20 percent) compared to Medicaid (12 percent) and Medicare (10 percent).[121] Eighteen percent of insured adults reported experiencing denied claims in the past year. In a review of MCO-reported claims denials from December 2017 to 2018, New York State issued 20 citations for inappropriate claims denials.[122] When claims are denied, consumers may have to pay out of pocket. When they are unable to pay, service providers are forced to absorb the costs. A 2024 survey by the Commonwealth Fund found that nearly 45 percent of consumers had received a medical bill or were charged a copayment in the last year for a service they thought should be covered.[123]

Clawbacks

Providers participating in commercial insurance contend with another form of claim denials called insurance clawbacks. Insurance clawbacks refer to the practice where insurance companies reclaim payments that were previously made to healthcare providers, often months or even years after the services were rendered.[124] These recoupments typically occur when an insurer retrospectively determines that a payment was made in error, whether due to coding issues, changes in patient coverage, or other discrepancies.

For providers, clawbacks can be financially burdensome, as they may be required to repay substantial sums long after services were delivered.[125] This practice not only creates financial instability for providers but also adds to the administrative burden, as they must review and contest clawback requests. Clawbacks can further strain the provider-insurer relationship and, in the behavioral health sector, may discourage participation in insurance networks, limiting access to care for patients.

Examples of How Issues with Denials and Clawbacks are Being Addressed

The National Alliance for Mental Illness has designed a guidebook for consumers to help them with navigating claims processing,[126] and Forbes magazine has published tips for consumers about how to appeal a denial.[127] And there is a whole website dedicated to processes for challenging denied claims provided by the Patient Advocate Foundation.[128]

Federally, HealthCare.Gov provides specific instructions for both internal and external appeals of denials. Internal appeals are when a consumer goes directly to the insurer requesting a review of the denial. External reviews are when a consumer asks for a third party to review the denied claim with the hope of overturning the decision. Many states also offer information on their websites to assist consumers with navigating the external appeal process. For example, in New York State, the Department of Financial Services website has a direct link to a portal to submit external appeals. Chapter 586 of 1998 in New also allows for providers and insurers to request an external appeal to obtain payment from a plan when there is a retrospective adverse determination.[129]

In 2016, New York State enacted Chapter 512, which amended the state's insurance law and public health law to include a consumer-friendly appeals process that ensures timely responses to override requests.[130] If an insurer or review agent fails to respond within the legally required timeframe, the appeal is automatically granted in favor of the patient.[131] Under an earlier enacted provision of state Insurance Law (§ 3224-b(b)), there is a 24-month recoupment limitation intended to address the challenges of clawbacks. However, the amount of the funds recouped even within that time frame can be very challenging to service providers.

Options and Opportunities for Addressing Barriers Due to Denials

States can follow the lead of groups that have attempted to educate, inform, and empower people to navigate denials and potentially appeal them by providing additional education and information to a wider range of the potentially impacted population. This might even include additional outreach to populations with a higher rate of denials. States can also assist consumers by requiring education to be provided *by an insurer* to any consumer with a denied claim. States may mandate this through an internal appeal or an external review process and work with one another to navigate the process when a consumer is in a different state than the provider. If the state has a consumer assistance program, the program can also file an appeal on behalf of the consumer. States can make consumers more aware of these programs so that more denied care or claims have an opportunity for review.

Conclusion

The increased demand for behavioral health services suggests that federal and state policymakers may want to explore more ways to improve insurance policies in ways that will result in better access to behavioral health. As identified in this paper, there are several ways governments are approaching insurance-related barriers that may impede access to behavioral health. There is no one way to improve access and coverage but rather a range of options for federal and state policymakers to consider, from improving network adequacy and coverage parity to modifying prior authorizations or minimizing denials of care. The good news is that many states have been paying attention to this important issue and in doing so, have provided numerous examples of ways to tackle this critical issue.

The following are some of the options and opportunities identified that federal and state governments can use to improve insurance access and coverage for behavioral health services. Of note, a national set of standards written into federal law would help address barriers due to variations in policies for insurers under the oversight of different states.

- Enhance enforcement of behavioral health parity laws to ensure equal coverage for mental health and substance-use disorder services with other health services, including among commercial and public plans. States may employ more rigorous monitoring and enforcement measures of insurance companies, including making data and policies publicly available and easily accessible.
- Make behavioral health services more affordable by reducing financial barriers for patients, such as addressing high costs of out-of-network care, high deductible health plans (HDHPs), and gaps in insurance coverage.
- Simplify or eliminate unnecessary administrative barriers, such as pre-authorization requirements that delay and can result in an unnecessary denial

of essential behavioral health services. This also might include implementing a standardized and electronic prior authorization system.

- Enhance the accessibility of behavioral health providers within insurance networks by increasing reimbursement rates and ensuring compliance with network adequacy regulations. Adequate networks increase the likelihood that an individual receives timely care, as services that are out of network, or not covered by insurance, are often cost-prohibitive.
- Educate consumers about their right to appeal a denied claim and equip them with the support necessary to effectively navigate the complaints process, including for plans that are under the oversight of other states.
- Ensure payment from public insurance programs such as Medicaid is adequate to cover the cost of care by raising reimbursement rates or requiring minimum payment levels to providers when a consumer has private insurance. Consider a complete review of Medicaid reimbursement for behavioral health services.
- Evaluate and identify strategies to mitigate disruptions in care during insurance transitions.

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