COALITION FOR WHOLE HEALTH

August 31, 2016

Cecilia Muñoz
Director, Domestic Policy Council
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Ms. Muñoz,

On behalf of the Coalition for Whole Health, a coalition of national, state, and local organizations advocating for improved coverage for and access to mental health (MH) and substance use disorder (SUD) prevention, treatment, rehabilitation, and recovery services, thank you for your continuing work to ensure equal coverage of and meaningful access to mental health and substance use disorder care through strong ACA (Affordable Care Act) and MHPAEA (Mental Health Parity and Addiction Equity Act) regulations, guidance, technical assistance and other related efforts by the administration. Good implementation and enforcement of the federal MH/SUD parity law is central to the success of the administration's major substance use disorder and mental health initiatives. The federal MH/SUD parity law and the ACA present the greatest opportunities our nation has ever had to dramatically improve access to care for these diseases that afflict many tens of millions of Americans.

Regrettably, eight years after becoming law, the full promise of the federal MH/SUD parity law has not yet been realized. Most states are not actively enforcing the law. People in need of MH and SUD care continue to face significant problems in accessing effective, evidence-based services and medications. When MH and SUD services and medications are covered by plans, it is often difficult to access the clinically appropriate type, amount and duration of care. These coverage and access problems continue to be more onerous for people with MH and SUD care needs than for people with other chronic health conditions. To make the requirements of the federal MH/SUD parity law meaningful, we, the seventy undersigned national, state and local organizations, urge the federal government, through the Department of Health and Human Services, Labor and Treasury, to directly and actively enforce the law to the extent States are not effectively enforcing the law for commercial insurance and Medicaid plans.

As millions of Americans are in critical need of life-saving mental health and substance use disorder care, the need for strong enforcement of the federal parity law by State and federal officials must take on a heightened level of urgency. The following is a summary of our concerns and recommendations for the Task Force, followed by more detailed comments and recommendations for your consideration:

1. **The federal government should issue additional specific guidance to State regulators and plans on how to implement the federal parity law, identify parity violations, and enforce the law in both public and private insurance.**

2. **The federal government should issue additional guidance detailing the parity law's transparency requirements and modeling for issuers the appropriate disclosure of coverage and plan design information.**
3. **Federal and State regulators should robustly enforce the requirements of the federal MH/SUD parity law prospectively during plan approval and retrospectively through complaint investigations.**

Through the work of the Coalition for Whole Health and many of its organizational members, we have seen many critical gaps and restrictions in insurance plan coverage of substance use disorder and mental health care, even when equitable coverage is required by the federal parity law and consumers are paying for what should be comprehensive benefits. Studies by the Coalition for Whole Health, American Society for Addiction Medicine, National Alliance on Mental Illness (NAMI), National Center on Addiction and Substance Abuse, Legal Action Center and state-based organizations have documented many problems. These include deficiencies in most states' benchmark plans that result in the failure of many essential health benefit (EHB) based insurance plans to cover services, or the coverage of non-comparable and limited services, including intensive out-patient, residential and recovery support or chronic disease management services, and medications. And even when insurance plans do cover services, they often impose more burdensome obstacles to obtaining that care, including inappropriate denials based on lack of medical necessity, prior notification or authorization and repeated authorizations, step therapy and other medical management. Access to care is further hindered by inadequate provider networks that do not include providers that offer the full range of covered services or specialize in adolescent care.

Consumers responding to NAMI's 2015 Coverage for Care Survey identified a number of these challenges in accessing MH care:

- According to one respondent, "I don't even try to use the mental health benefits anymore provided by my insurance company. It requires pre-authorization by one of their providers. My psychiatrist isn't in any network. I have been going to her for over 20 years. She is part of the reason I'm still on this earth. I spend roughly $175 per month to see her - and it's worth it. I would spend less money on food, if I had to, rather than stop seeing her."
- Another consumer shared, "The majority of the mental health professionals in my area do not participate in any insurance plans. The in-network providers do not have the same level of quality care. Thus, I must use my out of network benefits to get any insurance coverage for the psychiatrists, therapists, and outpatient treatment centers. My insurance plan has an $8000 deductible for out of network benefits, and then the coverage is 80% of UCR, which is a meager portion of what the doctor actually charges. For example, the psychiatrist charges $215 and the insurance reimburses me $60 because that is what they determine to be UCR. We have depleted all our savings and incurred much debt to get the quality mental health care we need."

These personal experiences, which are shared by many across the country, signal MHPAEA violations.

Several additional examples of parity compliance problems demonstrate that we are missing the opportunity to address our nation's horrendous heroin/opioid epidemic and the unacceptably large treatment gap for both MH and SUD care. Many insurance plans:

- Do not cover all three of the FDA-approved addiction medications – buprenorphine, methadone, and injectable naltrexone -- and some even perversely exclude methadone for its original purpose of treating opioid use disorder, even as they cover the medication for pain treatment. It is thus not surprising that a study just published in *Health Affairs*[1] found that insurance financing has not increased for substance use disorder treatment.
- Do not cover or restrict access to residential SUD treatment and eating disorder care, even when treating professionals determine a needed length of stay based on clinical criteria, despite covering comparable levels of care for other chronic health conditions;
- Do not cover services that help people to manage their disease and maintain wellness, such as MH/SUD recovery support services, even though those are needed every bit as much for on-going addiction and mental health care as they are for the management of other chronic diseases for which coverage is provided.
- Often require inappropriate medical management such as prior notification or authorization or step therapy when fail-first can mean death-first. It is hard to fathom how rational and evidence-based strategies and standards could allow prompt access to cancer or heart disease medications and services but not to lifesaving MH and SUD medications and services.

The results of these failures to comply with parity are literally deadly. Following these comments are a small sample of the many news media articles from around the country reporting complaints from families who lost children or were forced to pay out-of-pocket when insurance companies refused to reimburse for needed care. In addition, a large number of people with untreated serious mental illness or SUD are in county and local jails because they lack good health insurance coverage and access to MH and SUD care. On any given day, up to three-quarters of the jail population suffers from these illnesses. Robust enforcement of the federal MH/SUD parity law will better ensure that people will receive the services and medications they need to avoid disease, or to become, and remain, well.

Following are our detailed recommendations:

1. **The federal government should develop additional specific guidance to State regulators and plans on how to implement the federal MH/SUD parity law, identify parity violations, and enforce the law in both public and private insurance.**

The final MHPAEA regulations have created a strong legal framework, but more detailed federal guidance to State regulators, including insurance departments and Medicaid agencies, and issuers is needed. Using concrete examples, this guidance should clarify what the federal MH/SUD parity law requires and provide additional detail about best-practices that States can implement as they monitor and enforce federal law. The federal government should provide additional clarity and communication about

[1] Health Aff (Millwood). 2016 Jun 1;35(6):958-65. doi: 10.1377/hlthaff.2016.0002.
Insurance Financing Increased For Mental Health Conditions But Not For Substance Use Disorders, 1986-2014.
Mark TL, Yee T, Levit KR, Camacho-Cook J, Cutler E, Carroll CD.

state regulator roles and responsibilities related to enforcement, including clearer guidance about how corrective action should be taken. This should include:

- Guidance on the use of Medicaid and private insurance claims data, which is available through State Medicaid offices and, in many states, all payers claim data bases to identify trends that will uncover system-wide violations of the federal parity law. The data would reveal reimbursement patterns from which regulators can readily identify utilization management strategies (notification, authorization, and fail first requirements) that result in disproportionate denials of care for MH and SUD care. The data would also reveal gaps in provider networks by tracking members' disproportionate use of out-of-network services for MH and SUD services.
- Guidance on the use of market conduct surveys and examinations to identify violations in the use of non-quantitative treatment limitations. The guidance can provide sets of questions that state insurance departments can use to assess compliance across all plans as well as identify the need for more targeted enforcement actions and imposition of penalties and remedial actions. We recommend that HHS, CCIIO and DOL examine the experiences of States, including Connecticut, Maryland, Massachusetts, Rhode Island, and West Virginia, that have been utilizing market conduct exams as a part of their MHPAEA compliance process.
- Specific templates for oversight of the scope of benefit coverage and analytical framework for non-quantitative treatment limitations are needed to make parity requirements as clear, practical and concrete as possible for plans and state regulators. While regulators are familiar with MHPAEA's standards, guidance in operationalizing those standards will help states evaluate carrier standards and evidence of compliance on the front end of plan certification as well as respond to individual complaints. For example, regulators can identify common metrics that carriers use to implement utilization management requirements, set reimbursement rates and develop provider networks. We suggest that HHS, CCIIO and DOL consider the templates, checklists, and model contract language developed by California, Maryland, Oregon, and New York. Equally important, federal agencies should identify ways that carriers can test whether such requirements are imposed more stringently on mental health and substance use disorder benefits. Guidance on quantitative analysis of claims and other carrier data, grounded in an understanding of insurance practices, is needed to aid regulators and consumers.
- We recommend that HHS and CCIIO issue guidance to States on how to simplify and clarify the process for consumer complaints, clearly outlining what consumers need to file and to whom. The current complaints process for MHPAEA problems can be confusing and inaccessible because insurance regulation is a complex web of federal and state regulation. We urge HHS and CCIIO to improve the complaints process to ensure that timely and accurate data is collected about the problems consumers are experiencing with their health coverage so that these issues can be addressed by the appropriate regulatory body. For example, HHS and CCIIO could establish an easy-to-use national consumer complaint web portal or toll-free telephone hotline that collects basic information on a potential parity violation. This information would then be submitted to the appropriate State and federal enforcement agencies.
- We also strongly urge CCIIO and HHS to develop and release a parity analysis framework that federal, State, and other regulators would be required to use to supplement deficient Essential Health

Benefit coverage. Final guidance should include a detailed framework for regulators, consumers, and others that explains with specificity and clarity how to apply the requirements of parity to the EHB benchmarking process. This guidance should include specific examples of how plans should determine whether financial requirements and quantitative treatment limitations that are applied to MH and SUD benefits meet the substantially all/predominant test required by the law, and whether the scope of benefits and other non-quantitative treatment limitations meet the comparability standards. States, insurance commissioners, insurance exchanges and plans, Medicaid directors and managed care organizations, providers, consumers, and others need to know how the requirements of MHPAEA apply to MH and SUD coverage and what would constitute a violation. A detailed framework outlining requirements, with examples of violations and a process for bringing coverage into compliance, is very much needed.

- We appreciate explicit inclusion of MH and SUD service providers in network adequacy requirements for Medicaid and the commercial market and look forward to continued work by the federal government to ensure these protections are meaningful. The final parity rule identifies standards for provider admission to participate in a network, provider rates, and treatment limitations based on facility type and provider specialty as examples of non-quantitative treatment limitations that must comply with the federal parity law. We urge the federal agencies to develop specific guidance to State regulators on how to monitor and determine whether these network adequacy requirements of the federal MH/SUD parity law are being met. Federal regulators should look to the Maryland Insurance Administration's 2014-15 market conduct examination of network adequacy and rates (and its preliminary and final orders requiring remedial actions) for guidance on both the survey and investigative steps required to identify parity violations.

2. The federal government should issue additional guidance detailing the parity law's transparency requirement and modeling for issuers the appropriate disclosure of coverage and plan design information.

The Coalition continues to hear from our members, affiliates and stakeholder networks around the country that it remains very difficult for many consumers and advocates to obtain complete coverage information, including information about benefits and medications covered, medical necessity criteria and network MH and SUD providers. We are pleased by transparency and disclosure requirements (including the recently issued FAQ 31), but also urge the federal regulators to make clear in additional guidance that issuers should designate a parity compliance officer who has access to all plan documents that the carrier has relied upon in designing its benefits and testing for parity compliance so that prospective and current plan members, as well as regulators, can readily access this information. Strong enforcement of these disclosure requirements by the States and the federal government is needed.

Federal regulators must also make public information about what they are requiring plans to do to comply with the federal MH/SUD parity law. When regulators determine that certain coverage does not comply with the federal MH/SUD parity law, and work with a plan to bring the coverage into compliance, the release of de-identified information through FAQs, bulletins or other mechanisms about standards that violate the law would help other plans to comply more effectively. Plans, consumers, providers and advocates all agree that a feedback loop is essential to develop a body of precedent that can guide plan design. State insurance departments make their orders public, and the federal agencies must do the same.

3. Federal and State regulators should robustly enforce the requirements of the federal MH/SUD parity law prospectively during plan approval and retrospectively through complaint investigations.

The federal government should require Exchange plans to provide comprehensive information that demonstrates plan compliance with the federal MH/SUD parity law as part of the plan certification process. State insurance departments should be encouraged to require the same for all other commercial plans. This will better ensure that State regulators have sufficient information to assess compliance prior to the sale of a plan and places the primary responsibility for compliance on issuers, which have all the relevant information, rather than consumers. While form review provides important information for compliance reviews, all too often carriers identify and impose key NQTLs, such as utilization review requirements, in documents that are not reviewed by insurance departments, including provider contracts and member portal materials. Plan design information on other NQTLs, such as network admission standards and reimbursement rates, are not generally a part of plan review. As a result, state insurance departments cannot assess plan compliance without carriers disclosing all plan design features. California has operationalized a comprehensive prospective review of all NQTLs, and we urge the federal government to adopt this as a "best practice."

As mentioned earlier, the CWH and other groups in the MH/SUD community have on a number of occasions brought to the attention of federal regulators parity violations in the 2017 EHB benchmark plans which largely determine coverage in each state, including benefit exclusions for medication assisted treatment, eating disorder care and residential addiction treatment; gaps need to be filled, but stakeholders are unclear whether deficient benchmark plans have been supplemented and brought into compliance system-wide.

To highlight a few specific examples of the benefit coverage problems:

- Medication-assisted treatment (MAT): There are continuing, systemic problems with accessing MH and SUD medications. For substance use disorder medications: plans fail to include certain SUD medications on drug formularies, even as patients with other types of chronic health conditions have significant choice in medications based on medical advice, and the exclusion of Methadone Maintenance Therapy (MMT) is widespread. For example, in February of 2015, an Alabama consumer contacted one of the Coalition's member organizations as he was attempting to enroll in Marketplace coverage. Upon reviewing AL's coverage options, he found that neither of the two issuers operating on the Marketplace covered MMT, which he had been receiving for the previous couple of years and which had helped him to maintain his recovery. In a second example, a major carrier in Maryland denied reimbursement for methadone treatment in its 2015 and 2016 EHB-based plans in both the individual and small group markets, even though methadone treatment is a covered benefit in the Maryland benchmark benefit. When the MIA investigated the violation, the carrier claimed to correct the problem, but has instead continued to deny coverage under a range of other "denial codes" and has imposed restrictive utilization review when all other denial options fail.

  Medications are a critical piece of the continuum of care for all chronic illnesses. There are only three federally approved medications to treat chronic opioid addiction. Excluding coverage for a medication that been an important part of the continuum of care for people with opioid addiction is contrary to established national standards of care. To address the nationwide heroin/opioid epidemic

and ensure good access to each of the small number of highly effective, approved medications, we urge the federal regulators to issue clear guidance that (1) parity requires coverage of all three SUD medications for opioid dependence, as well as medications for other SUDs, and (2) use of fail first, prior notification or authorization and other policies that disproportionately restrict access to SUD medications violates parity.

- Coverage exclusions or the application of more onerous medical management tools that restrict access to eating disorder care.
- Review of available plan information suggests that preventative services and interventions that help people maintain wellness are more often covered by plans for other chronic health conditions than for MH and SUD. We need explicit guidance that parity requires a comparable array of MH and SUD preventive interventions and chronic disease management/wellness promotion services for adults and young people.
- We continue to see coverage gaps for intermediate levels of care despite guidance that partial hospitalization, residential treatment and intensive outpatient treatment must be covered at parity with intermediate levels of care for other illnesses. In addition, some plans incorrectly classify intensive outpatient treatment and partial hospitalization as "inpatient" services, even though such services do not meet the plan definition of hospitalization or inpatient care. This misclassification as an inpatient service imposes greater cost-sharing requirements on consumers and other NQTL requirements on those services that may result in denials of care.

For plans required to comply with the EHB requirements of the ACA, States should be precluded from certifying that they are providing EHB in mental health and substance use disorder benefits without complete information on which to determine that these benefits comply with the federal parity law. At a minimum, plans should submit a written assurance as part of the plan approval process that each plan offered is fully compliant with the requirements of the law and have all supporting documentation readily available through the carrier's designated parity compliance officer. In addition, State regulators must ensure that federal parity law violations that are identified through a member's individual complaint are corrected for all plan members immediately and plan modifications are communicated promptly to all members so that they can assert their right to full benefits.

For plans that have a federal agency as the primary oversight agency (ex: ERISA plans overseen by DOL), we would appreciate a greater understanding of the process for monitoring parity compliance and ensuring that deficient plans come into compliance with the law. When violations are reported or noted, a corrective plan should be required and made public so that members may enforce their rights to equitable coverage. We ask the federal regulators to consider the compliance monitoring approach CMS outlined in the final Medicaid and CHIP Managed Care Final Rule. This protocol could be adapted to private insurance and made available to State regulators.

We urge the federal government to provide State regulators with not just written materials and tools but with targeted technical assistance. We urge the federal government to engage in both technical assistance and training around the requirements of the federal parity law for commercial insurers and Medicaid. Technical assistance should be directed to State health insurance departments, State health, MH and SUD commissioners, Medicaid directors, insurers themselves, the national associations that represent insurers. Mental health and substance use disorder service providers and consumer advocates who are familiar with insurance barriers to treatment should help inform the technical assistance

curriculum. This technical assistance should be very practical, problem-specific and demonstrate by clear examples compliant and non-compliant quantitative and non-quantitative treatment limitations. Continuing resources should be provided to ensure that each State receives training and technical assistance on enforcing the federal MH/SUD parity law.

A public education campaign on the rights and benefits of the federal MH/SUD parity law should be established, funded, and directed toward consumers and health care providers. This campaign should provide concrete examples of standards that raise "red flags" for potential violations and define a clear path for reporting suspected parity violations. When violations are reported and verified, corrective action should be taken to correct the plan standard for all members, not just restitution for the complainant.

In closing, thank you again for the tremendous leadership this administration has displayed in enacting and implementing strong inclusion of mental health and substance use disorder services at parity in national health care reform. We look forward to continuing to work with you. We appreciate that there will be a continuing role for the public/stakeholders to help inform the work of the Task Force. We pledge to continue to be a resource in helping this Task Force to ensure there is meaningful access to quality care to help people avoid disease or become and remain well.

Sincerely,

National Organizations:
American Association on Health and Disability
American Association for the Treatment of Opioid Dependence (AATOD)
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association Practice Organization
American Public Health Association
American Society of Addiction Medicine
Association for Ambulatory Behavioral Healthcare
Center for Clinical Social Work/ABE/ACSWA
Clinical Social Work Association
Community Access National Network (CANN)
Community Catalyst
Council on Quality and Leadership
Faces & Voices of Recovery
Facing Addiction
General Board of Church and Society - United Methodist Church
Harm Reduction Coalition
The Institute for Behavioral Healthcare Improvement
International Society of Psychiatric-Mental Health Nurses (ISPN)
The Kennedy Forum
Lakeshore Foundation
Legal Action Center
Mental Health America
NAADAC, the Association for Addiction Professionals
National Association of Addiction Treatment Providers

National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)
National Association for Rural Mental Health (NARMH)
National Association for Children of Alcoholics (NACoA)
National Association of County and City Health Officials
National Alliance on Mental Illness (NAMI)
National Alliance of State & Territorial AIDS Directors (NASTAD)
National Association of Psychiatric Health Systems
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Association of State Mental Health Program Directors (NASMHPD)
The National Center on Addiction and Substance Abuse
National Council for Behavioral Health
The Parity Implementation Coalition
ParityTrack
Partnership for Drug-Free Kids
Project Inform
Sargent Shriver National Center on Poverty Law
School Social Work Association of America
The Thomas Scattergood Behavioral Health Foundation
Treatment Communities of America
Treatment Research Institute

State and Local Organizations:
AIDS Foundation of Chicago
The Association of Community Mental Health Authorities of Illinois
Colorado Center on Law and Policy
Colorado Coalition for Parity
Colorado Mental Wellness Network
Consumer Health First (Maryland)
County Behavioral Health Directors Association of California
Drug Policy and Public Health Strategies Clinic, University of Maryland Francis King Carey School of Law
Equitas Health (Ohio)
Illinois Association for Behavioral Health
InnerWisdom, Inc. (Texas)
The Lorain County Board of Mental Health (Ohio)
Maryville, Inc. (New Jersey)
Mental Health America of Los Angeles
Mental Health Association of Maryland
Minnesota Recovery Connection
NAMI Nevada
NCADD-MD
New Jersey Association of Mental Health and Addiction Agencies
New York Association of Psychiatric Rehabilitation Services, Inc.
Saginaw County Community Mental Health Authority
Salt Lake County Behavioral Health Services
University of IL College of Medicine

APPENDIX

Media Coverage of Insurance Denials for Mental Health and Substance Use Disorder Care

CALIFORNIA:

Jenny Gold, *Is Mental Health "Parity" Law Fulfilling its Promise?*, CNN, September 20, 2015, http://www.cnn.com/2015/09/20/health/mental-health-parity-law/

> "When Michael Kamins opened the letter from his insurer, he was enraged.
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> His 20-year old son recently had been hospitalized twice with bipolar disorder and rescued from the brink of suicide, he said. Now, the insurer said he had improved and it was no longer medically necessary for the young man to see his psychiatrist two times a week. The company would pay for two visits per month.
>
> "There was steam coming out of my ears," Kamins recalled, his face reddening at the memory of that day in June 2012. "This is my kid's life!"
>
> His son again became suicidal and violent, causing him to be rehospitalized eight months later, said Kamins, a marketing professor at the State University of New York, Stony Brook. Kamins is suing the insurer, OptumHealth Behavioral Solutions, which disputes his version of events and denies that it left the young man without sufficient care."
>
> *The article also addresses problems with "fail first" insurance policies.*

CONNECTICUT:

Reed Abelson, *Lacking Rules, Insurers Balk at Paying for Intensive Psychiatric Care*, NEW YORK TIMES, Sep 27, 2013. http://www.nytimes.com/2013/09/29/business/lacking-rules-insurers-balk-at-paying-for-intensive-psychiatric-care.html

> "The first time Melissa Morelli was taken to the hospital, she was suicidal and cutting herself, her mother says. She was just 13, and she had been transferred to a psychiatric hospital, where she stayed for more than a week. Her doctors told her mother, Cathy Morelli, that it was not safe for Melissa to go home. But the family's health insurance carrier would not continue to pay for her to remain in the hospital.
> The second time, the same thing happened. And the third and the fourth. Over the course of five months, Ms. Morelli took Melissa to the hospital roughly a dozen times, and each time the insurance company, Anthem Blue Cross, refused to pay for hospital care. "It was just a revolving door," Ms. Morelli said.
>
> "You had not been getting better in a significant way," Anthem explained in one letter sent directly to Melissa, then 14, in July 2012. "It does not seem likely that doing the same thing will help you get better."

> Desperate to get help for her daughter, Ms. Morelli sought the assistance of Connecticut state officials and an outside reviewer. She eventually won all her appeals, and Anthem was forced to pay for the care it initially denied. All told, Melissa spent nearly 10 months in a hospital; she is now at home. Anthem, which would not comment on Melissa's case, says its coverage decisions are based on medical evidence.
>
> Melissa's treatment did not come cheap: it ultimately cost hundreds of thousands of dollars, Ms. Morelli said. Patients often find themselves at odds with health insurers, but the battles are perhaps nowhere so heated as with the treatment of serious mental illness."

ILLINOIS:

Judith Graham, *Since 2008, Insurers Have Been Required by Law to Cover Mental Health – Why Many Still Don't*, THE ATLANTIC, March 11 2013, http://www.theatlantic.com/health/archive/2013/03/since-2008-insurers-have-been-required-by-law-to-cover-mental-health-why-many-still-dont/273562/ .

> "Danielle Moles, who lives in LaGrange, Illinois, has experienced the problem first hand. Moles, 32 years old and a nurse, has anorexia and exercise-induced bulimia, complicated by major depression. She's been hospitalized repeatedly and denied residential treatment and intensive outpatient care several times by her insurance company, which provided coverage for the large hospital where she worked.
>
> Mole admits to being suicidal at times. Unable to get the help she needs, she said, "I will sit there and cry so hard I can't catch my breath. This is the worst kind of torture, and I don't want the next person to go through it.""

NEW JERSEY:

Dan Goldberg, *Insurance Companies Frustrate N.J. Families Seeking Addiction Treatment*, NEWARK STAR-LEDGER, Feb 17, 2013,
http://www.nj.com/news/index.ssf/2013/02/new_jersey_heroin_insurance_tr.html

> "Denise Mariano and her son Michael had been at Princeton House since 9:30 in the morning. It was now after 5 p.m. and the doctors at the in-patient rehabilitation facility were still fighting with Mariano's insurance company. Michael was going through withdrawal. Denise was desperate.
>
> The doctors, according to his mother, told Michael he'd have better luck with the insurance company if he had a dual diagnosis: a drug addict who was also mentally unstable.
>
> Would he, they asked, be willing to say he was going to harm his mother or himself. If Michael was mentally unstable, they could admit him, Denise said. And his insurance would cover that.
>
> Michael refused. The 18-year old from Roxbury was a drug addict using as many as 40 bags of heroin a day, but not a sociopath. And even though the doctors wanted to help it wasn't up to them — not really.

It was the insurance company that had the final say.

Denise ended up paying thousands of dollars out of pocket to get her son a room for a few nights in 2011 before her insurance agreed to cover outpatient therapy."

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"Kyle Buchta was told in 2009 he needed detox and 30 days of in-patient rehabilitation, according to his mother Sheila. His insurance denied the in-patient treatment and wanted out-patient treatment tried first, she said.

Back in his Little Egg Harbor home, Buchta, then 19, continued using heroin. He was in and out of out-patient programs, some court ordered, some paid for out of pocket. He held and lost jobs. The cycle continued until his death by overdose last July."

Heroin Addicts Face Barriers to Treatment, ASSOCIATED PRESS, April 7, 2014, http://www.foxnews.com/health/2014/04/07/heroin-addicts-face-barriers-to-treatment.html

"In the course of Marchese's five-year battle with heroin, the young man from Blackwood, N.J., was repeatedly denied admission to treatment facilities, often because his insurance company wouldn't cover the cost. After abusing marijuana and prescription painkillers as a teenager, Marchese had turned to heroin for a cheaper high.

Then one night in June 2010, a strung-out, 26-year-old Marchese went to the emergency room, frantically seeking help. The doctors shook their heads: Heroin withdrawal is not life-threatening, they said, and we can't admit you. Doctors gave him an IV flush to clean out his system, and sent him home.

Marchese and his sister stayed up all night calling inpatient treatment centers only to be told: We have no beds. We'll put him on a waiting list. Call back in two weeks.

As Marchese grew sicker with diarrhea, body aches and shakes, his sister tried a new tack. She called one more place and told them her brother was using heroin and also drinking alcohol. That did the trick, because alcohol withdrawal can cause life-threatening seizures.

He was admitted the next morning, and released 17 days later when his funding from the county ran out. Less than three months later, Marchese was found dead of an overdose in his mother's car, a needle and a bag of heroin on the center console."

NEW YORK:

Liz Szabo, *Addiction Treatment Hard to Find, Even as Deaths Soar*, USA TODAY, May 24, 2015, http://www.usatoday.com/story/news/2015/05/24/addiction-treatment-shortage/27181773/.

> "Linda Ventura said her insurance company told her that her son, Thomas, would have to "fail first" in outpatient treatment before it would pay for inpatient treatment for his heroin addiction.
>
> "If you relapse, the insurance company says, 'We paid for this before. We're not paying for it again," said Ventura, from Kings Park, N.Y. "But if you come out of remission with cancer, do they say, 'You had four treatments. We're not paying?'"
>
> Ventura has become an advocate for substance abuse treatment since Thomas' death from a heroin overdose in 2012, when he was 21."

Lou Michel, *Troubles Mount for Families of Opiate Addicts when Insurers Won't Pay for Treatment*, BUFFALO NEWS, May 8, 2016, http://www.buffalonews.com/city-region/troubles-mount-for-families-of-opiate-addicts-when-insurers-wont-pay-for-treatment-20160508

> "When a health insurance company canceled a 48-year-old man's medicine to weaken his dependence on heroin, he made a desperate call to his 77-year-old mother. Now she is paying $130 a week for his Suboxone prescription.
>
> A teenager hooked on opioids has been told that his health insurance refuses to cover the full stay for his inpatient treatment. His parents have shelled out thousands of dollars.
>
> Then there is Avi Israel. His son Michael committed suicide five years ago after the family's health insurance refused to pay for his stay at a detox facility.
>
> At a time when fatal heroin and opioid overdoses have risen to unprecedented rates – 10 suspected opiate overdose deaths a week in Erie County – many area families complain that health care insurers are denying coverage for loved ones seeking medication and inpatient treatment for their addictions."

PENNSYLVANIA:

Despite Law, Parity in Mental Health and Addiction Treatment Can Be Elusive, PHILLY.COM, March 7, 2016. http://articles.philly.com/2016-03-07/business/71249956_1_mental-health-parity-parity-law-addiction-equity-act

> "Five years ago, Valerie Furlong's life was in turmoil.
>
> Both of her teenage sons, raised in South Jersey about 20 minutes from Camden, had become addicted to opiates.
>
> Yet when she tried to get them into rehabilitation centers, one of them was denied outright and the other was deemed ready for outpatient care after just two weeks, which would have put him

right back into the environment where he became addicted - before it was safe to do so, Furlong said.

That experience led Furlong to dedicate herself to ensuring that a 2008 federal law that requires insurance plans that cover mental illness and addition to treat those conditions the same as physical ailments.

"When I started getting these letters of denial and realized that many people would not be able to deal with it, I decided that I was not going to go away quietly," said Furlong, who estimated that she and her husband have spent $50,000 to $60,000 on their sons' care because of insurance denials."

Ron Lieber, *Walking the Tightrope on Mental Health Coverage*, NEW YORK TIMES, Dec 21, 2012, http://www.nytimes.com/2012/12/22/your-money/walking-the-tightrope-on-mental-health-coverage.html.

"Amanda Griffiths, who lives in Carlisle, Pa., and is the mother of two autistic boys, called 17 providers within two hours of her home before finding one who was qualified to evaluate her younger son and was accepting new patients his age.

"No amount of insurance is going to magically make a provider appear," she said.

And it remains a struggle to persuade insurance companies and employers to cover treatment that is new or expensive, even if it's likely to be effective."

Ben Allen, *When Rehab Might Help an Addict – But Insurance Won't Cover It*, NATIONAL PUBLIC RADIO, Aug 16, 2015. http://www.npr.org/sections/health-shots/2015/08/16/430437514/when-rehab-might-help-an-addict-but-insurance-wont-cover-it

"Growing up in the Philadelphia suburb of Warrington, Anthony Fiore checked all the boxes for a typical American guy. He'd go to the gym, play video games and watch football — in his case, the Eagles. His mom, Valerie Fiore, was proud of him.
"Anthony was very intelligent," she says. "He breezed through his high school, Central Bucks South — he never studied. He aced his SATs. He got right into Penn State's main campus."

But before he could get to Penn State, the powerful painkiller Oxycontin got hold of him. Soon afterward, he moved on to heroin.

In May 2011, Anthony tried a 21-day rehabilitation stint in Florida. About a year later, he checked in to another facility, but only for 11 days. By the third attempt at inpatient rehab, Anthony said he really wanted to get help and would stick it out.
"That was a 21-day treatment. And that's when I had Premera Blue Cross," Fiore says. She begged the staff at the rehab-center to keep treating her son at their facility for longer than 21 days. "And that gentleman said to me, 'Your insurance will not cover any more.' "
The family couldn't afford to foot the bill for a longer stay, Valerie Fiore says. So Anthony left that facility in November 2013. Six months later, he was dead of a heroin overdose."

WEST VIRGINIA:

Tamara Keith, *Politics in Real Life: Dying from Overdose while Waiting for Treatment*, NATIONAL PUBLIC RADIO, May 12, 2016. http://www.npr.org/2016/05/12/477652738/politics-in-real-life-dying-from-overdose-while-waiting-for-treatment

> "Courtney Griffin was addicted to heroin and ready to get help. She packed up her things, and her mom drove her to a residential treatment facility about an hour from their home in New Hampshire. There was a bed waiting for her.
>
> But unfortunately, that's not where her story ends. Ninety minutes after they arrived, Pamela Griffin said, her daughter was back in the waiting room, shaking her head. Their health insurance company declined to cover the treatment.
>
> "They declined, saying that it wasn't a matter of life and death," said Pamela Griffin, recounting the rejection. "And Courtney said, 'This drug is going to kill me.' She knew."
>
> Without insurance, the treatment would cost $12,000. They left not knowing what to do. The hope of treatment and the letdown of not being able to get it were devastating for the Griffin family.
>
> Less than two months later, Courtney Griffin was dead."

NATIONWIDE:

Jeffrey Borenstein, President and Chief Executive of the Brain and Behavior Research Foundation, Letter to the Editor, NEW YORK TIMES, April 26, 2016.

> "The vast majority of people who die as a result of suicide have a psychiatric condition like depression, bipolar disorder, schizophrenia or post-traumatic stress. To decrease the number of suicides, we need to improve access to care by enforcing the insurance parity laws so that people are not denied treatment."