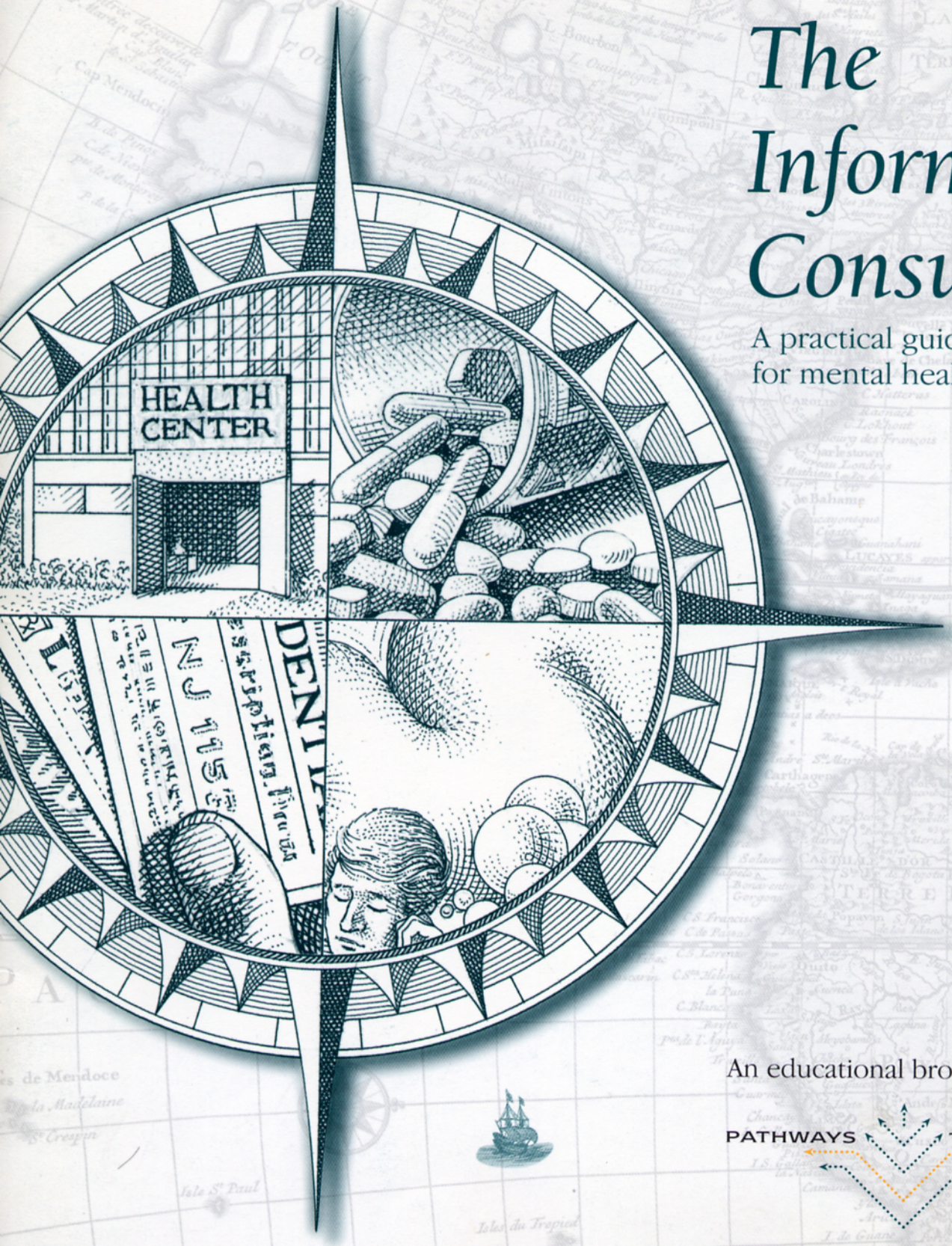

The Informed Consumer

A practical guide to paying for mental healthcare

An educational brochure from

PATHWAYS TO CHANGE™

JANSSEN · PHARMACEUTICA · RESEARCH FOUNDATION ·

How to navigate through the mental healthcare system.

Getting started.

This brochure will assist people with mental illness to better understand their mental healthcare insurance and medication coverage. Whether you are new to all this or an experienced hand, this brochure can be a helpful resource. Since many of the words used in the brochure may be new to you, we have also included a glossary of reimbursement and healthcare terms.

Mental illness is no different than medical illness.

Mental illness is a medical illness, just as diabetes or heart disease. Mental illness is a physical condition, a complicated medical disorder that affects the brain. Since mental illness often requires long-term treatment with medication and psychotherapy, insurance coverage is crucial.

Treatment is critical.

Many medications are available to treat mental illness. The value of early intervention, and the use of appropriate medication are immeasurable; they can help you, the mental health consumer, avoid a lifetime of suffering and give you the best chance for recovery. That's why it is so important that you know how to get the services and insurance you need.

The more you know.

By educating and speaking up for yourself, you may be able to get services that are not specified in your plan. *When it comes to coverage, don't hesitate to ask questions!* Understanding your mental healthcare benefits is important; in fact, this is an area of your life where you can take control and make choices that are right for you. To find out about insurance "exceptions to the rule," talk with your physician, patient advocacy representative, social worker, and/or your insurance carrier. By becoming an informed consumer, you are empowering yourself and ensuring that you receive the necessary services and treatment.

Different types of coverage.

People with severe mental illnesses, such as schizophrenia, often seek and receive services through public insurance plans such as Medicaid; state or community mental health programs; Medicare, and managed care organizations (MCOs). Others may get mental healthcare coverage through places of employment and/or private insurance companies, health maintenance organizations (HMOs), or other MCOs. Each of these coverage plans is described in more detail in the following sections.

Please note that this brochure will not explain all the details of your particular plan. To ensure that you receive the coverage and services you need, it's important that you review and understand your insurance policy before you actually use it. Don't wait until you're in an emergency!

What you need to know about Medicaid.

Who is eligible?

Typically, Medicaid provides healthcare coverage for families and individuals with low incomes, such as those who are receiving Temporary Assistance for Needy Families (TANF) or are on Supplemental Security Income (SSI). However, in most states, Medicaid coverage is available to the "medically needy," typically described as those for whom the need and cost of care is greater than their ability to pay for it.

What services are available through Medicaid?

Hospital stays.

State Medicaid programs cover inpatient psychiatric care in general hospitals. However, your doctor must approve your admission in advance. Inpatient coverage may also be restricted by the number of days that are covered—15 days per year is the average. While Medicaid will pay for your mental healthcare in general hospitals, it usually DOES NOT cover care provided in psychiatric hospitals.

Outpatient care.

If you do not need to be treated as an inpatient at a hospital, you may benefit from outpatient care. Outpatient programs may involve weekly or daily visits to a clinic or counseling center. (Proper utilization of such programs may help optimize mental health and reduce the need for inpatient hospitalization.) In order to get Medicaid coverage for such a program, you will need to undergo an evaluation

Generally, Medicaid will not pay for inpatient hospitalization at psychiatric hospitals. However, there are exceptions: Medicaid will typically cover treatment in a psychiatric hospital (including medications) *if you are 21 years or younger, or 65 years or older.*

If you don't fall into either of these age groups, your stay will most likely be covered by your state department of mental health (DMH). (See below.) However, the benefits provided may vary from state to state. For specific information, contact your state DMH.

What services do state mental health programs provide?

State mental health programs provide inpatient psychiatric hospital coverage to patients aged 22 to 64 years who would not otherwise be covered by Medicaid. State mental health programs offer inpatient and outpatient services in a variety of settings, including state psychiatric hospitals, general hospitals, and community mental health centers (CMHCs).

by a doctor, nurse, or social worker. If one of these healthcare team members determines the program is appropriate for you, Medicaid will pay for you to participate. Your medications will be paid for by an outpatient prescription drug program, which is described below.

MEDICATION COVERAGE.
All state Medicaid programs offer outpatient prescription drug programs. If you are on Medicaid, Medicaid will give you a prescription drug card that you must present to the pharmacist who fills your prescription(s). You will receive your medication free, or for a nominal copayment; however, Medicaid may require that you seek their approval before the drug is dispensed.

Please note: In most cases, the hospital will provide you with some *medication before you are discharged. The amount of medication can range from a week's to a month's worth.*

CMHCs typically dispense drugs through their facility's pharmacy or a pharmacy network. In some cases, however, medications may be paid for (in part) by Medicaid, or provided to the participant by the CMHC. Because this varies from program to program, you should look into the specific coverage plan offered at your local CMHC.

Medication Alert.

Because it may take 4 to 8 weeks to qualify (or requalify) for Medicaid after being discharged from a hospital, it may be difficult to get your medication costs reimbursed during this transition period. If this presents a problem for you, talk with your doctor or social worker to find out about intermediary coverage options.

Medicaid under managed care.

Many states now use managed care organizations (MCOs) to deliver mental healthcare to Medicaid beneficiaries, rather than using the state mental healthcare system. To find out more about this, you should speak with your local Medicaid representative, or other advisory organizations such as your local AMI office.

What you need to know about Medicare.

Who is eligible?

Medicare is a federally funded program that provides health services to elderly or severely disabled individuals. If you have received Social Security Disability Insurance for at least 2 years, you may also be eligible for Medicare.

What services are available through Medicare?

Medicare has two parts: Hospital Insurance (Part A), and Supplementary Medical Insurance (Part B).

- **Part A** helps pay for inpatient hospital stays, skilled nursing facilities, or home care
- **Part B** helps pay for physician services including visits to a psychiatrist; outpatient hospital care, such as group therapy; and medications that are not self-administered

PSYCHIATRIC INPATIENT SERVICES.
Under certain conditions, Medicare will cover psychiatric services. For example, Medicare will provide coverage if a physician has certified that the admission can be "reasonably expected to improve the patient's condition."

PSYCHIATRIC OUTPATIENT SERVICES.
Medicare provides coverage for psychiatric visits, just as it covers visits to a medical doctor for other physical illnesses.

Important information about Medicare deductibles and copayments.

For both inpatient and outpatient services, the patient is responsible for paying a portion of the cost of care, either as a deductible or as a copayment.

- ***Deductibles*** are amounts that you must pay before Medicare starts to pay. For example, if you have a yearly deductible of $100 and your first hospital bill for the year is $750, you pay $100 and Medicare pays the remaining $650.

  (Please note: Medicare Part A and Part B have separate deductibles.)

- ***Copayment*** is the amount associated with your bill that is your responsibility. For example, Medicare typically pays 80% of outpatient services; you are responsible for paying the remaining 20%.

  (Please note: Generally, there is no copayment for inpatient hospitalization.)

Partial hospitalization.
Medicare covers partial hospitalization services, such as individual and group therapy and medications. However, Medicare will only cover the expense of group therapy if suggested by your psychiatrist as an alternative to admittance to a psychiatric hospital. Only drugs administered by a physician are covered.

Skilled nursing facilities and other extended care facilities.
If, after receiving inpatient care, you are transferred to a skilled nursing or other extended care facility, Medicare will cover your treatment if you were in the hospital for at least 3 consecutive days and were transferred to the nursing facility within 30 days after hospital discharge.

Medication coverage.
Medicare provides different types of medication coverage, dependent upon the type of care you are receiving. For example, Medicare does not cover prescription drugs received from a retail pharmacy. Medicare beneficiaries usually rely on supplemental health insurance programs such as Medigap, or their own state's expanded drug coverage program to pay for their outpatient medications.

Should I purchase supplemental health insurance with Medicare?

In order to be covered for the health expenses that Medicare does not pay, you may want to purchase supplemental health insurance such as Medigap insurance. Medigap, for example, covers required Medicare copayments. *Whether purchasing Medigap will save you money depends on your specific mental healthcare needs. Medigap is a smart investment if your Medicare copayments are more expensive than your Medigap payments.*

Medicare under managed care.

In certain cases, Medicare recipients are eligible to enroll in managed care plans that include a prescription benefit. If you have a choice between managed care plans, be sure to ask about and compare the prescription benefits provided.

What you need to know about private insurance.

There are over 1200 private insurance companies that offer health insurance policies to individuals and groups. Examples of private plans include Aetna, John Hancock, Prudential, Metropolitan, and Cigna.

Who is eligible?

Private insurance is often a benefit of full-time employment. Dependents of a full-time employee may also be eligible for coverage. You may also choose to purchase private insurance coverage.

What services are offered through private insurance carriers?

Large insurance companies offer many plans with a wide range of benefits or services. Employers work with the insurance company to design benefit packages exclusively for their employees. A few of the more common services are described below.

INPATIENT HOSPITALIZATION.
Acute inpatient care is covered by all commercial plans; although copayments, deductibles, and day limitations may vary. The typical policy requires the person with mental illness to pay a deductible and/or a copayment of up to 20% on all services.

OUTPATIENT SERVICES.
Nearly all commercial plans cover outpatient services. Copayment obligations for outpatient and physician services are usually 20% of the amount charged, or the amount approved by the plan as "usual, customary and reasonable" (UCR).

How does the UCR rate work?

Typically, an insurance carrier will have a preset limit on how much it will spend to cover certain services. If, for example, a plan's UCR rate for a psychiatric visit is $100, and your psychiatrist charges $150 per visit, the plan will cover only $100, and you would then be expected to pay the remaining $50 (unless the psychiatrist would reduce his/her fee).

Q&A

Physician services.
Typically, a patient is required to pay the total cost of physician services and then file a claim for reimbursement with the insurance plan. Many carriers, however, expect patients to pay the physician only the required copayment or deductible, with the carrier submitting the remaining balance.

Medication coverage.
Medication coverage varies by plan. While insurance carriers commonly offer coverage of prescription drugs with a 20% copayment, many are now offering drug card services. These services provide coverage with a nominal copayment, which does not vary regardless of the cost of the drug. However, the copayment may be reduced or waived when generic medications are used to fill the prescription.

Requirements and limitations.

Copayment requirements.
Plans usually require patients to pay a deductible or copayment. However, there is often a limit on the amount a patient or family is required to pay. After this limit has been reached, the plan covers 100% of medical expenses for the remainder of the time the patient is covered under that plan, up to the plan's lifetime maximum payment. Unfortunately, in some commercial plans, this deductible may not apply to drug and/or mental health benefits.

LIFETIME MAXIMUM BENEFITS.
Most plans have a lifetime maximum, which is the maximum amount that will be paid for an individual's healthcare expenses. Lifetime maximums vary according to each plan, but may range from $250,000 to more than $1,000,000 per individual.

Reimbursement criteria.

PRIOR AUTHORIZATION.
Many plans require prior authorization of non-emergency inpatient and outpatient services. If you do not get prior authorization, your insurance company may refuse to cover your costs. Emergency services must also be approved by the plan within a certain period of time. Ask your physician and insurance carrier what specific type(s) of documentation is (are) required under these types of circumstances.

What is a Preferred Provider Organization (PPO)?

Through PPOs, patients receive care from a group of physicians, hospitals, and other healthcare providers that have been selected by a private insurance carrier. When patients use these preferred providers, copayments and deductibles may be reduced or waived. Some plans offer additional benefits when preferred providers are used. If necessary, you can obtain care from providers who are not on this list, but at a higher cost. It is important to note that *PPOs are not HMOs*.

What you need to know about private Health Maintenance Organizations and other managed care organizations.

Health maintenance organizations and managed care organizations are increasingly important sources of healthcare. If you are covered by such a plan, you will receive your mental healthcare at a hospital or from a doctor who is associated with your HMO.

Who is eligible?

HMO membership is typically provided through an employer's healthcare plan. The employee contributes to the cost with premium payments that are deducted from his or her paycheck. HMOs also offer plans to individuals who are not working.

What services are available through HMOs?

Inpatient care.
The plan contracts with selected hospitals to provide specific services to members at discounted rates.

Coverage for nonemergency situations.
Members of HMOs must see a primary care physician for a referral to a specialist. In managed mental healthcare plans, nonemergency evaluation by a psychiatrist or social worker is usually required before psychiatric services will be covered.

Medication coverage.
As part of the inpatient or outpatient services, HMOs cover drugs prescribed by physicians. In addition, HMOs usually have discount programs with a number of retail pharmacies that fill prescriptions in accordance with the copayment schedule established by the HMO.

Reimbursement.
In general, HMOs or other managed care plans pay hospitals and doctors directly; however, you may be required to submit a copayment.

A glossary of terms used in mental healthcare.

In addition to healthcare terms that appear in this brochure, we have also included definitions of other words that may be helpful to you.

ACUTE PSYCHIATRIC TREATMENT: treatment, usually for an emergency, which lasts less than 30 days, in comparison to **extended psychiatric treatment,** which lasts more than 30 days.

CARVED-IN PLANS: a plan under which the state awards contracts to one or more companies to provide all medical health services.

CARVED-OUT PLANS: under managed care, states may separate or "carve out" funds for mental healthcare and give them to a company that specializes in such services. These companies are called *behavioral health MCOs.*

CATEGORICALLY NEEDY: any person who receives welfare payments through Temporary Assistance for Needy Families (TANF), or Supplemental Security Income (SSI) for the blind, elderly, or disabled.

CMHC (COMMUNITY MENTAL HEALTH CENTER): an outpatient treatment center that provides mental healthcare; usually administered by a state department of mental health.

COPAYMENT: the amount a person covered by insurance must pay for a service; the insurance plan pays the remainder. For Part A Medicare, there is no copayment for the first 60 days of hospital care. For Part B services, the patient is responsible for 20% of Medicare-approved charges.

DEDUCTIBLE: the amount a person covered by insurance must pay each year before the insurance plan will pay for covered expenses.

DRG (Diagnostic-Related Group): a system of classifying inpatient hospital services according to principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and complications. Used as a guide by insurance companies in reimbursing hospitals for services.

Dual diagnosis: the presence of more than one disorder in the same individual.

Dual eligible: those persons who qualify for both Medicare and Medicaid because of age, mental illness, and financial need. Also referred to as a Qualified Medicare Beneficiary (QMB).

Extended psychiatric care: treatment that lasts more than 30 days, as opposed to **acute psychiatric care,** which lasts less than 30 days.

HCFA (Health Care Financing Administration): the agency of the federal government that administers Medicare and Medicaid. It is part of the Department of Health and Human Services.

HMO (Health Maintenance Organization): an organization that provides specific health services for a fixed, prepaid amount of money.

Inpatient: a person who has been admitted to a hospital and receives treatment for at least 24 hours.

Managed care: any system of delivering healthcare services that attempts to control cost and use of services.

MCO (MANAGED CARE ORGANIZATION): a company that manages the cost and quality of healthcare by limiting the member's choice of providers to those in a network. Some MCOs permit use of out-of-network providers at additional cost.

MEDICARE: the national health insurance program for people 65 years of age and older, for certain younger disabled people, and for people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Because of the disabling effects of severe mental illness, many people with schizophrenia and other psychiatric disorders qualify for Medicare.

MEDICALLY NEEDY: a term to describe people for whom the cost of medical care is greater than their ability to pay. In some states, those who qualify for Supplemental Security Income (SSI) are automatically deemed medically needy, while SSI recipients in other states may be eligible for Medicaid.

MEDICAID: the joint federal and state program that provides healthcare to low-income people. Each state is responsible for providing its own Medicaid program within broad federal requirements. As a result, Medicaid programs vary greatly from state to state and over time.

MEDIGAP: also called Medicare supplement policy, this is an insurance policy that pays the policyholder's deductibles and copayments not covered by Medicare, as well as paying for additional services, depending on the cost of the policy. The federal government has defined 10 standard Medigap policies labeled A through J. Only the most expensive plans (H, I, and J) include reimbursement for prescription drugs.

OUTPATIENT: a person who receives treatment without being admitted to a hospital, as in a doctor's office.

PPO (PREFERRED PROVIDER ORGANIZATION): a group of physicians, hospitals, and other healthcare providers that provides services to persons covered by a particular insurance plan. Members are encouraged to use these providers, as they offer reduced copayments, although they can usually use nonpreferred providers at a higher cost.

PRIOR AUTHORIZATION: the requirement that certain diagnostic tests, surgical procedures, and prescription drugs be approved in advance by the MCO before they can be performed or prescribed.

SKILLED NURSING FACILITY: an institution, commonly called a nursing home, that houses patients whose needs are less demanding than those of hospital patients. Among other services, such a facility assists its members in the activities of daily living.

SSI (SUPPLEMENTAL SECURITY INCOME): cash payments provided through the Social Security Administration to the disabled, blind, and elderly, under certain circumstances.

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