

HEALTH PLAN CHECKLIST

How to determine if your plan provides REAL mental health care

Provided by The National Coalition of Mental Health Professionals and Consumers, Inc.
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1. Can you get a full diagnosis and treatment by a highly trained mental health professional?
2. Can you use any licensed clinician or are you limited by a list of “preferred providers?” Lists limit your choice of clinician, especially if your income is limited. (Many patients today cannot find a clinician with whom they are comfortable because of these limits. Some can’t find anyone at all, as many of these lists are “phantom lists” containing names of clinicians who no longer take new patients or are no longer on the list.)
3. If you must use a list of “preferred providers,” is there a sufficient range of clinicians that includes specialists and subspecialists (e.g., in adolescent, family therapy; in eating disorders; addictions; etc.)?
4. If there is a “list,” do you have immediate access to out-of-network clinicians when needed?
5. Is “medical necessity” decided by you and your clinician or by a “case manager” who doesn’t know you and never meets you; who uses their company’s “clinical guidelines” to determine how much of what kind of treatment you need?
6. Can you choose the type of mental health therapy you feel fits your needs or are you limited to “brief” “symptom-focused,” or “problem-focused” therapies or limited to generic medications? Does your plan provide for individual, couples, group, and family therapy; generic and brand-name medications as prescribed by your clinician; biofeedback; etc.? Are there “fail-first” requirements or excessively high co-payments before you can use the newest or most effective medications? (This can be dangerous for those with serious mental illnesses.)
7. Can you stay in treatment as long as is needed, as decided by you and your clinician?
8. Are hospitalization and day treatment centers available when you and your clinician believe they are necessary?
9. Does your plan provide for separate units or programs for children, adolescents, the elderly, and those with addictions or disabilities?
10. Is your treatment private? Does your plan require only a diagnosis, dates of treatment, type of treatment, and fee to process your claim or does your plan “manage” your care by requiring personal information from your clinician about your symptoms and problems in order to “authorize” sessions? (Many people decline therapy or feel they have to pay out of pocket to ensure privacy, making it unaffordable to many who need privacy for their mental health.)
11. Can you remain in treatment with the professionals you like at the facilities you like when your insurance changes, when your job changes?
12. Is the behavioral or mental health portion of your insurance administered by a different company than the rest of the health care benefits? (Often, these “carve-outs” discriminate against those with mental health problems.)
13. Are there different benefit limits to mental health care than there are for physical health care?
14. Are all psychiatric diagnoses in the DSM and ICD-9 (published lists of diagnoses accepted by the mental health professions) covered?
15. Do you have to get referrals, pre-authorizations, call 800 numbers, or go through other gatekeepers or screening mechanisms before seeing the right mental health professional? (Access should be direct, with no obstacles to treatment.)
16. Does your plan allocate 8-10% of all health care expenditures to mental health care? (If not, it is under funding mental health care.)

The above are the essentials for quality mental health plans and insurance. Mental health problems include serious mental illness, addictive disorders, and emotional problems, and all should be covered in order to have a physically and mentally healthy nation. If your plan does not have all you need, speak to your employer or to your union, to the actual people who negotiate and contract for your plan.