NAVIGATING INSURANCE AND AFFORDABILITY BARRIERS IN BEHAVIORAL HEALTH CARE

Maanasa Kona, Stacey Pogue, Madison Harden-Stein, Zeynep Celik, and Sloane Daly

Executive Summary

The United States continues to face a severe behavioral health (BH) crisis, with nearly one in three adults reporting a mental illness or substance use issue in 2024. Although effective treatments exist, financial and insurance-related barriers prevent many people, particularly those in underserved communities, from accessing and sustaining care. This report, the fourth in a five-part series supported by the National Institute for Health Care Reform, examines how insurance design, affordability dynamics, and safety net capacity shape access to BH services. Drawing on a literature review and 26 interviews with state officials, payers, providers, and researchers in Michigan, New Mexico, and Virginia, the report analyzes how coverage gaps persist even among insured populations and how states can mitigate these affordability barriers.

This report finds that people with BH conditions face unique and heightened affordability barriers. BH treatment often requires frequent, ongoing engagement over long periods of time. As a result, affordability is not determined by the price of a single visit, but by the cumulative exposure to costs and administrative demands over months or years. Interviewees emphasized that this dynamic fundamentally changes how insurance works for people with BH conditions, turning otherwise manageable financial or administrative requirements into persistent barriers that undermine treatment initiation and continuity. These pressures are particularly acute for people with unstable incomes or limited capacity to navigate complex insurance rules.

Funding for this report was provided by the National Institute for Health Care Reform

GEORGETOWN UNIVERSITY McCourt School of Public Policy
CENTER ON HEALTH INSURANCE REFORMS

Maintaining continuous insurance coverage is itself a major challenge for many people with BH needs. Interviewees across all three study states highlighted how eligibility restrictions, Medicaid redetermination processes, and administrative complexity lead to frequent coverage disruptions. These challenges are amplified for people with serious mental illness or substance use disorders, whose conditions can make it difficult to track paperwork, deadlines, and renewal notices. Providers have responded by embedding enrollment assistance within BH settings, and in some cases, states and counties have created coverage backstops for people who cannot access traditional insurance options. However, interviewees emphasized that these solutions are often fragile and highly dependent on local political support and fiscal capacity.

For people with BH conditions, affordability is shaped not only by whether care is covered, but by how coverage is structured and administered. Interviewees consistently described four interrelated categories of insurance-related barriers: high cost sharing, coverage exclusions, utilization management practices, and inadequate provider networks. High cost sharing deters both entry into care and sustained engagement. Coverage exclusions related to provider type, service type, or care setting leave patients without access to intermediate levels of care or multidisciplinary supports. Utilization management practices can delay or deny clinically appropriate services and impose substantial administrative burdens on providers. Network inadequacies, driven by workforce shortages, low reimbursement, and provider nonparticipation, often force patients to seek care out of network or rely on safety net providers despite having insurance.

Mental health parity laws have reduced some of the most overt disparities between BH and non-BH coverage, particularly by limiting differential quantitative treatment limitations, such as more restrictive visit caps or higher cost sharing on BH services. However, interviewees described parity as less effective in reducing disparities related to non-quantitative treatment limitations, including prior authorization requirements, medical necessity criteria, and network management. Enforcement challenges, limited regulatory resources, and the complexity of parity analysis constrain its impact. As a result, states are supplementing their parity enforcement with more prescriptive policy tools, such as prohibitions on cost sharing for BH services (as in New Mexico) or statutory requirements that coverage decisions align with generally accepted standards of care (as in Virginia), which are easier to administer and enforce.

The report also highlights the critical role of the BH safety net in absorbing gaps created by insurance design and affordability failures. Federally Qualified Health Centers, Community Mental Health Centers, Certified Community Behavioral Health Clinics, free clinics, and hospital emergency departments often function as de facto secondary or tertiary coverage for underinsured and uninsured patients. While these providers are essential to maintaining access, interviewees emphasized that safety net capacity is uneven and constrained by workforce shortages and reliance on unstable funding sources, contributing to fragmented and inconsistent access across communities.

Medication affordability presents an additional challenge for both insured and uninsured populations. For insured patients, access to psychiatric and substance use disorder medication is frequently constrained by cost sharing, formulary placement, and utilization management requirements. Uninsured patients, by contrast, rely on fragmented and administratively complex pathways, such as manufacturer assistance programs and charitable pharmacy arrangements, which interviewees described as uneven, fragile, and prone to disruption.

Taken together, these findings show that coverage instability, gaps in coverage, and safety net fragility reinforce one another, leaving many people without reliable access to ongoing treatment. Improving access therefore requires coordinated policy approaches that strengthen not only insurance coverage, but also the systems that support uninsured and underinsured patients when coverage falls short.

KEY RECOMMENDATIONS FOR STATE POLICYMAKERS

- **Ensure Access to Coverage:** Reduce coverage churn by simplifying Medicaid renewals, funding enrollment assistance in BH settings, and providing wraparound subsidies for low-income Marketplace enrollees.
- **Make Coverage Usable:** Reduce or eliminate cost sharing for high-value BH services and medications in state-regulated plans; limit deductible exposure for essential BH care; and require continuity-of-care protections when benefits, formularies, or networks change.
- **Reduce Administrative Barriers:** Restrict prior authorization and step therapy for evidence-based BH services and medications; standardize utilization management across Medicaid managed care plans; and require transparent reporting of denial and appeal outcomes.
- **Strengthen Networks and Parity Enforcement:** Update BH network adequacy standards to reflect real access; protect consumers when networks fail; and pair parity enforcement with bright line benefit and utilization requirements.
- **Improve Medication Affordability:** Limit cost sharing and utilization management for essential BH medications; require transition fills when formularies change; and support centralized infrastructure to help patients and providers navigate medication access pathways.
- **Align Data and Oversight:** Track and publicly report indicators of affordability-related access barriers and strengthen cross-agency coordination among Medicaid, insurance regulators, and state BH authorities.