Depression

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A resource for people with depression and their loved ones.

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DEPRESSION DIAGNOSIS & TREATMENT

Depression, also known as major depressive disorder, is a common and serious mental illness,[1] causing feelings of sadness and lack of interest in activities that can lead to both emotional and physical problems at home and at work.[2] During the COVID-19 pandemic, rates of depression increased from 36.4% to 41.5%.[3]

Symptoms of depression include, but are not limited to, persistent sad, anxious or "empty" moods; feelings of hopelessness or pessimism; irritability; feelings of guilt, worthlessness, or helplessness; loss of interest from hobbies and activities; decreased energy or increased fatigue; moving or talking slowly; feeling restless; difficulty concentrating, remembering, or making decisions; difficulty sleeping or oversleeping; appetite and weight changes; and aches, pains, headaches, cramps or digestive problems.[4]

Depression can occur in anyone at any time. However, biochemistry, genetics, personality, and environmental factors can also play a role in the development of depression.[5] In addition, some forms of depression can occur based on certain type of circumstances or life events, such as during pregnancy and postpartum.[6]

It is also a common co-morbid condition to several chronic diseases including arthritis, Alzheimer's disease, autoimmune diseases, cancer, chronic lung disease, diabetes, epilepsy, HIV/AIDS, hypothyroidism, heart disease, multiple sclerosis, and stroke.[7] As such, treatment is uniquely challenging as providers must treat both the depression and the co-occurring condition. Fortunately, studies how shown that treating co-occurring depression can also improve patients overall medical condition and result in better medication compliance for the co-occurring conditions.

There are multiple types of depression such as persistent depressive disorder, postpartum depression, psychotic depression, seasonal effective disorder, and bipolar disorder.

Persistent depressive disorder is classified as depression that lasts at least two years.[8] Persistent depressive disorder is considered a chronic condition that 3% of people in the United States will experience at some point during their lifetime.[9] This form of depression is more common in women and individuals who have relatives that have been diagnosed with this condition.[10]

Postpartum depression occurs in women after pregnancy.[11] However, in some cases women can experience this form of depression during pregnancy, which is known as perinatal depression.[12] Postpartum depression is more than the "baby blues" which are often experienced

by mothers as a result of feeling tired, worried, and overwhelmed with caring for a newborn.[13] Postpartum depression occurs when these feelings last longer than two weeks or the feeling of anxiety and unhappiness are considered severe.[14] Seventy five percent of women experience the "baby blues", and approximately 15% of these women will develop postpartum depression.[15]

Psychotic depression occurs when an individual has depression and some form of psychosis, such as delusions or hallucinations.[16] Of the up to 11% of people who will experience severe depression, roughly 14.7% to 18.5% of these individuals will develop psychotic depression.[17]

Seasonal affective disorder is a form of depression that occurs during winter months when there is less natural sunlight.[18] Every year between 10% and 20% of people develop seasonal affective disorder.[19] While this form of depression typically occurs in people over the age of 20, the likelihood of developing seasonal affective disorder decreases with age.[20] Seasonal affective disorder is less common in states like Florida that do not experience a significant decrease in sunlight during winter months.[21]

Bipolar depression is experienced in people who have been diagnosed with bipolar disorder in which their mental states alter between mania and severe depression.[22] There are two types of bipolar disorder – Bipolar I Disorder and Bipolar II Disorder.[23] Individuals living with both types of bipolar disorder can experience depression. Bipolar disorder affects approximately 2.3 million people in the United States, which is the equivalent to nearly 1% of the United States population.[24]

It is estimated that depression costs patients, caregivers, the healthcare system, and employers nearly $44 billion per year in lost wages, absenteeism, secondary events and urgent care in addition to other more hidden costs such as presenteeism in which employees are present at work but not engaged.[25] Depression can also impact employee's performance as depression can impair focus, decision making, time management, social interaction, and communications. Moreover, not effectively treating depression directly impacts patients' ability to adhere to medications for co-morbid conditions such as substance abuse disorders or migraine disease, resulting in cascading costs to the healthcare system and difficulty managing patient outcomes.

Treatment for patients with various depressions is not one-size fits all. Patients with depression can receive treatment in the form of medications, psychotherapies, brain stimulation therapies, and some developing prescription digital therapeutics.[26] Patients can receive one of these treatments or a combination of these treatments.[27] Medications used to treat depression include selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), atypical antidepressants, tricyclic antidepressants, and monoamine oxidase inhibitors (MAOIs).[28] Deciding on a course of treatment should be left to clinicians and patients, not dictated by insurers' burdensome utilization management schemes designed to protect company profits.

Health insurance companies often take a number of steps to reduce their costs related to depression diagnosis and treatment. Health plans may also limit coverage of certain treatments prescribed by your doctor, or the plan may require you to take a number of additional, and often unnecessary, steps before your treatment is approved.

The good news is that there are state and federal laws in place that may protect you from these practices.

To find out if your health insurer delayed or denied the depression treatments prescribed by your doctor, ask yourself the following questions:

STEP THERAPY

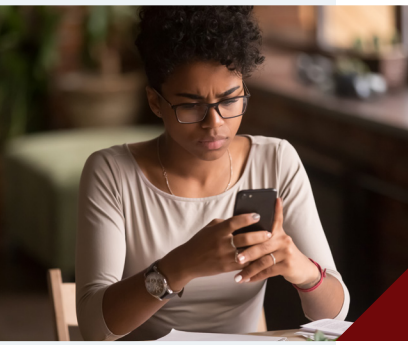
Did my insurer make me try a different treatment before covering the depression medication or therapy that my doctor prescribed?

This practice is called "step therapy" or "fail first" because it requires patients to try other treatments first and demonstrate that they do not work or are intolerable, often causing discomfort and burdensome experiences for the patient while they wait.[29] For patients with depression, step therapy can impact treatment effectiveness. For example, one study found that step therapy reduced the effectiveness of antidepressants and increased medical costs.[30] Step therapy policies may also be against federal or state laws if your insurer treats you and others with similar diagnoses differently because of your health condition.[31] Additionally, you may be entitled to an exception from the step therapy process.

NON-MEDICAL SWITCHING

Is my insurer forcing me to take a different medication, even though my current depression treatment is working, by refusing to cover it any longer or increasing my copay?

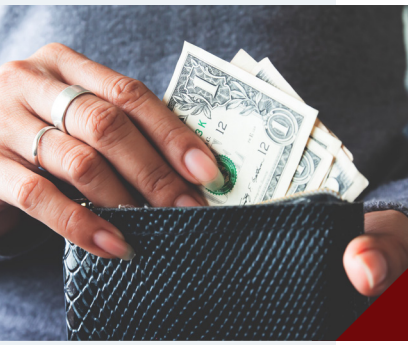
This practice is referred to as "non-medical switching." It occurs when your insurer (not your health care professional or pharmacist) forces you to switch from your current medication to a different (but not a generic equivalent) medication by either refusing to cover your drug any longer or increasing the out-of-pocket cost of your drug.[32] Non-medical switching is harmful for patients with depression. One study found that over a seven-year period, patients who were switched between several SSRI medications had less favorable outcomes, an increase in treatment resistance, and lower rates of remission.[33] Non-medical switching may also violate certain states' consumer protection laws.[34]



PRIOR AUTHORIZATION

Do I need to get my insurer's approval before I can begin or continue my prescribed depression treatment or therapy?

This practice is called "prior authorization." It happens when your insurer requires you or your doctor to get your insurer's approval before the treatment is covered. Approval is based on the insurer's standards, which may be inconsistent with medical standards of care. Prior authorization requirements impact medication adherence, with one study finding that patients with bipolar disorder who were subjected to prior authorization requirements had higher rates of treatment discontinuation.[35] For those living with some form of depression, the results can be devastating. These policies can also violate state and federal laws if applied in a certain manner.



ADVERSE TIERING

Do I have to pay a high copay for certain medications that treat my condition?

This practice is called "adverse tiering." It can be used by insurers to shift much of the cost for newer or innovative therapies to patients by placing expensive drugs on what are called "specialty tiers". Treating patients with mental illnesses is complex and many medications in the same class are not interchangeable.[36] Moreover, studies have shown that adverse tiering leads to higher rates of medication discontinuation in patients with mental illness.[37] Certain tiering policies may also violate certain federal and state laws if used in a discriminatory way.[38]

COPAYMENT ACCUMULATORS

If I receive coupons or discounts to help pay for my medication copays, does my insurer prohibit those coupons or discounts from counting toward my annual deductible?

This policy is known as a "copayment accumulator." Copayment accumulators force patients to pay more out-of-pocket when copayment assistance runs out and the insurance deductible has not been met. These policies are frequently buried in the fine print of insurance contracts and may violate state consumer protection laws.[39]

My insurer refuses to cover a depression treatment or therapy that my health care professional prescribed to me. **What can I do?**

If your insurer refuses to cover your treatment, here are three steps you can take to change your insurer's decision:

- Appeal the decision;
- Request an external review; or
- File a consumer complaint.

How do I appeal the decision?

If your insurer denies your claim, you have the legal right to an internal appeal.[40] This means you can ask your insurer to conduct a full and fair review of its decision. To appeal the denial, you should do the following:

Review the determination letter. Your insurer should have sent you a determination letter to tell you that it would not cover your claim. Review this document so you can understand why your insurer denied your claim and how you can appeal the denial.

Collect information. Collect the determination letter and all other documents the insurance company sent you. This includes your insurance policy and your insurer's medical necessity criteria. "Medical necessity criteria" refers to your insurer's policy for determining whether a treatment or service is necessary for your condition.[41]

Request documents. If you did not receive the determination letter or do not have your policy information, the medical necessity criteria, or the instructions and forms for filing an appeal, call the insurer's customer service representative and ask for these documents. The company website will list the toll-free telephone number to call.

Call your health care professional's office. The health care professional's office or clinic has people on staff to help with the appeal process. They will tell you how to fill out the forms to request an appeal, write an appeal letter on your behalf, or handle the appeal request for you.

Submit the appeal request. It is important for you or your health care professional's office to submit the appeal request as soon as possible along with the letter from the health care professional and all additional information the insurer requested.

Once you file an appeal request, expect to wait up to 30 days to hear back from the insurance company regarding a treatment you hope to receive. It can take up to 60 days for a response if you received the treatment and are waiting for reimbursement.

Follow up. Follow up with your insurer regularly until you hear back. Be sure to keep a record of the name of any representative you speak with about the appeal, the date and time you spoke with that person, a confirmation number for the call, and a summary of your discussion.

What if my insurer denies my appeal?

Under law, you are entitled to take your appeal to an independent third party for an "external review," which means the insurance company no longer gets the final say over whether to approve a treatment or pay a claim. The situation applies if the insurer denies your appeal or if your medical situation is urgent and waiting would jeopardize your life or ability to function.

How do I request an external review?

To trigger an external review, file a written request with the independent organization within 60 days of the date your insurer sent you a final decision. The process should take no more than 60 days. However, in urgent situations requiring an expedited review, the process should take no longer than four business days. To find out whom to contact in your state to request an external review, please go to www.CoverageRights.org.

How do I file a complaint?

If your insurer denies your coverage after the external review process, you can file a complaint with the insurance commissioner or attorney general in your state. To determine whom to contact and how to submit the complaint, please go to www.CoverageRights.org.

Your complaint should include the following information:

- The name, address, email address, and telephone number of the person filing the complaint ("Complainant");
- The name of the insured individual, if different from the Complainant;
- The names of any other parties involved in the claim (for example, the plan administrator or pharmacy benefit manager);
- The name of the insurance company and the type of insurance;
- The state where the insurance plan was purchased;
- Claim information, including the policy number, certificate number, claim number, dates of denial, and amount in dispute;
- The reason for and details of the complaint; and
- What you consider to be a fair resolution.

You should also submit the following supporting documents with your complaint:

- A copy of your insurance card;
- Copies of coverage denials or adverse benefit determinations from your insurer;
- Copies of any determinations made by internal and external reviewers;
- Any materials submitted with prior appeals and complaints;
- Supporting documentation from your health care professional;
- A copy of your insurance policy; and
- All responses from your insurer.

What happens after the insurance commissioner or attorney general receives my complaint?

The insurance commissioner or attorney general will assign someone to research, investigate, and resolve your complaint. That person will examine your account, records, documents, and transactions. He or she may question witnesses, request additional documents from other parties, and hold a hearing. If the insurance commissioner or attorney general determines that the insurer violated laws or regulations, he or she may order the insurer to give you the requested coverage or compensate you.

Whom should I call if I have any questions about filing a complaint?

To determine whom to call in your state, please go to www.CoverageRights.org.

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