

MENTAL HEALTH & ADDICTION CARE PARITY

A ROADMAP TO YOUR
RIGHTS & ACCESSING CARE

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TODAY YOU WILL LEARN ABOUT

- Your Rights Under the Mental Health Parity and Addiction Equity Law.
- Strategies To Help You Access Care.
- How To Appeal When Coverage is Denied.
- Self Advocacy – Resources That You Can Use!
- Advocating for Consumers – How to Assist Your Clients

THE MENTAL HEALTH PARITY
&
ADDICTION EQUITY ACT – AN
OVERVIEW-
MAKING THE LAW UNDERSTANDABLE

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PARITY DEFINED

- THE STATE OF BEING EQUAL. THE SAME.
- PARITY MEANS THAT TREATMENT FOR MENTAL HEALTH & ADDICTION OR SUBSTANCE USE DISORDERS IS NOT MORE RESTRICTIVE THAN FOR MEDICAL AND SURGICAL CARE.

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WHY DO WE NEED A PARITY LAW?

- **PURPOSE:** THE LAW WAS NEEDED BECAUSE IT WAS HARDER TO GET SERVICES TO TREAT MENTAL HEALTH AND ADDICTION or SUBSTANCE USE DISORDERS THAN IT WAS TO GET TREATMENT FOR OTHER MEDICAL CONDITIONS.

IS PARITY REQUIRED?

- NOT ALL HEALTH PLANS HAVE TO OFFER MENTAL HEALTH & ADDICTION BENEFITS.

WHAT PARITY GIVES CONSUMERS

PARITY MEANS THAT WHEN A HEALTH PLAN INCLUDES MENTAL HEALTH & ADDICTION COVERAGE, SERVICES MUST BE PROVIDED IN A WAY THAT IS EQUAL TO OTHER MEDICAL SERVICES.



IS PARITY REQUIRED?

- NOT ALL HEALTH PLANS HAVE TO OFFER MENTAL HEALTH & ADDICTION BENEFITS.

Exemptions

- Local and state self-funded government plans may apply for an exemption from the Centers for Medicare and Medicaid Services (CMS).
- MHPAEA does not apply to Medicare plans
- MHPAEA does not apply to TriCare/Department of Defense (DOD) plans

Cost Exemptions

- Plans that experience cost increases of more than 2% in the first year and 1% in the following year may file for an exemption
- Plans that drop coverage because the plan meets cost exemption criteria must inform plan participants of a reduction in benefits

IS MY HEALTH PLAN REQUIRED TO GIVE ME PARITY?

YOU GET PARITY FOR THESE PLANS!!!:

- Employer-funded plans with more than 50 insured employees
- Medicaid managed-care plans.
- Children's Health Insurance Program plans.
- Medicaid Alternative Benefit plans
- (Medicaid expansion) NOT in Wisconsin!
- Some small employer plans that existed before Parity (less than 51 employees)*
- Before Parity law individual market plans**
- Plans offered through the health insurance exchanges.
- Federal Employees Health Benefits Plans ***

PARITY DOES NOT APPLY TO:

- TRICARE/DOD plans
- Medicare plans
- Veterans Administration

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The Final PARITY Rule for Medicaid and CHIP

In this final rule, CMS applies certain provisions of the MHPAEA to requirements for Medicaid managed care organizations, Medicaid alternative benefit plans, and the Children's Health Insurance Program (CHIP).

The rule is designed to create consistency or **PARITY** between the commercial and Medicaid markets.

The final rule requires that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or CHIP be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system.

WHAT CHANGED WITH PARITY?

THE LAW ELIMINATES MORE
RESTRICTIVE LIMITS!

EXPLAINING NON-QUANTITATIVE TREATMENT LIMITS
non-financial – limits on treatment that do not involve calculations. It is how the plan is managed.

- Decisions about what kind of care you can get.
- For Example: when a plan pre-determines if a treatment is medically necessary for you.

EXPLAINING \$ QUANTITATIVE TREATMENT LIMITS

- Numerical limits placed on coverage or treatment. Financial decisions. For Example:
- The number of inpatient days you spend in a treatment facility.
- How many times you see a doctor.

PARITY: Who Enforces The Law?

Federal rules and regulations clarify that states have primary enforcement authority over health plans that offer insurance coverage in the state-licensed group and individual markets. As such, states are intended to be the primary means of enforcing implementation of MHPAEA.

The Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in states that do not comply. The Department of Labor has primary enforcement authority over self-insured ERISA plans.

PARITY: Who Enforces The Law?

The federal rules put states in charge of health plans that offer:

- insurance coverage in the state-licensed group plans.
- individual markets.

PARITY: Who Enforces The Law?

Wisconsin, through the Office of the Commissioner of Insurance, enforces the Federal LAW. State insurance commissioners oversee individual and employer-funded plans of less than 51 insured employees, as well as fully insured large group plans.

Mental Health Parity and Addiction Equality Act.
MHPAEA.

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PARITY: Who Enforces The Law?

- The Department of Labor (DOL) and the Internal Revenue Service generally have enforcement authority over self-insured private sector employment-based plans that are subject to the Employee Retirement Income Security Act (ERISA).
- Health and Human Services (HHS) has direct enforcement authority with respect to self-funded non-federal governmental plans.

PARITY: STATE VS. FEDERAL RULES – States Can Do More Not Less!

- States may provide more coverage than what is required by the Federal law but can not provide less!
 - Wisconsin Parity Law requires employers with more than 10 employees to provide Behavioral Health coverage for Mental Health and Substance Use Disorders.
 - Federal Law begins at 50 employees on most jobs

PARITY: STATE VS. FEDERAL RULES – States Can Do More Not Less!

- Wisconsin meets federal standards and also provides Transitional Treatment Services:
 - Mental Health & Substance Use Disorder treatment in a less restrictive environment than a hospital but in a more intensive manner than outpatient services.

WHAT SERVICES ARE COVERED BY THE PARITY LAW?

CONSUMERS NEED TO KNOW:

When am I *IN* and When am I *OUT*?

IF a health plan provides medical/surgical benefits in any or all of these categories:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency Care
- Prescription Drugs

the health plan MUST provide mental health/addiction benefits in the SAME categories

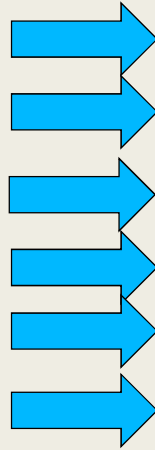
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This is what PARITY looks like!

MEDICAL & SURGICAL CARE

THAT YOU RECEIVE

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency Care
- Prescription Drugs



MENTAL HEALTH & ADDICTION CARE

THAT YOU RECEIVE

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency Care
- Prescription Drugs

EXAMPLES OF HOW PARITY WORKS:

A HEALTH PLAN CAN NOT CHARGE TWO DEDUCTIBLES

THESE CHARGES ARE ACCEPTABLE IF YOUR TOTAL DEDUCTIBLE IS \$500

DEDUCTIBLE FOR MEDICAL & SURGICAL SERVICES

- You Pay \$250
- You Pay \$200

AND

AND

DEDUCTIBLE FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS

- You Pay \$250
- You Pay \$300

TOTAL PAID = \$500

TOTAL PAID = \$500

THE HEALTH PLAN CAN NOT CHARGE TWO \$500 DEDUCTIBLES When the plan says that the Deductible TOTAL is \$500.

DEDUCTIBLE FOR MEDICAL & SURGICAL SERVICES

- If You Already Paid \$500

DEDUCTIBLE FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS

- You Can't Be Required to Pay another \$500 - THIS IS AN OVERCHARGE AND IS NOT ALLOWED.

EXAMPLES OF HOW PARITY WORKS:

A HEALTH PLAN CAN NOT DENY A CONSUMER THE RIGHT TO USE AN OUT OF NETWORK PROVIDER IF....

EXPLAINING HOW PARITY RULES ARE MET

MEDICAL & SURGICAL SERVICES

- You are allowed to see a doctor or go to a hospital that does NOT have a contract with your health plan

MENTAL HEALTH & SUBSTANCE USE DISORDERS

- You are allowed to see a doctor or go to a hospital that does NOT have contract with your health plan.

ENCOURAGE CONSUMERS TO BE SMART SHOPPERS!



- KNOW WHAT IS IMPORTANT TO YOU BEFORE CHOOSING A HEALTH CARE PLAN!

** A Full List of Key Things to Consider When choosing a Health Plan is included in the Take Home Packet.*

REMIND CONSUMERS TO COMPARE HEALTH INSURANCE PLAN BENEFITS BEFORE MAKING A CHOICE!

PLAN A OFFERS:

- Inpatient, in network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency Care
- Prescription Drugs

PLAN B OFFERS:

- Inpatient, in network
 - Outpatient, in-network
 - Emergency Care
 - Prescription Drugs
- * PLAN B DOES NOT PAY FOR OUT OF NETWORK TREATMENT. YOU WILL HAVE TO PAY 100% OF THE COSTS!**

ASK - WHICH PLAN IS BETTER FOR YOU?

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COMPARE OUT OF POCKET COSTS!

PLAN A OFFERS:

- Inpatient, in network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency Care
- Prescription Drugs

* PLAN A REQUIRES YOU TO PAY FOR THE FIRST \$1,000 IN COSTS BEFORE HEALTH BENEFITS KICK IN. A HIGH DEDUCTIBLE.

PLAN B OFFERS:

- Inpatient, in network
- Outpatient, in-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency Care
- Prescription Drugs

* PLAN B ONLY REQUIRES YOU TO PAY FOR THE FIRST \$250 IN COSTS BEFORE HEALTH BENEFITS KICK IN, BUT COSTS MORE PER MONTH.

ASK - WHICH PLAN IS BEST FOR YOU?

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SOME IMPORTANT THINGS FOR CONSUMERS TO CONSIDER

- FIRST, DOES THE HEALTH PLAN COVER MENTAL HEALTH & ADDICTION/SUBSTANCE USE DISORDER TREATMENT?
- ***REMEMBER** - NOT ALL HEALTH PLANS HAVE TO OFFER MENTAL HEALTH & ADDICTION BENEFITS.

CONSIDER WHAT IT COSTS FOR SOMEONE TO KEEP THEIR CURRENT DOCTOR

- IS MY CURRENT PRIMARY MENTAL HEALTH PROVIDER OUT OF NETWORK?

Find out how much the Health Plan makes you pay if you need to use a doctor, hospital, or specialist that is out of network.

Are They Willing To Change Doctors?

KEY FINANCIAL CONSIDERATIONS: PRESCRIPTION DRUG COVERAGE

HOW MUCH MONEY DOES THE PLAN PAY FOR
PRESCRIPTION DRUGS?



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The amount that a Health Plan will pay for prescription drugs will vary from plan to plan.

- **ASK- HOW EXPENSIVE ARE THE PRESCRIPTION DRUGS THAT YOU USE?**
- If you currently use prescription drugs on a regular basis or think you may need to in the future, you will want to consider a plan that has good prescription drug coverage.

KEY FINANCIAL CONSIDERATIONS TO ALERT CONSUMERS TO: WHAT WILL I PAY OUT OF POCKET IF I CHOOSE THIS HEALTH PLAN?

- You will want to know what your co-payments will be.
- **Co-payments** are the fees you need to pay when visiting your doctor, hospital, or emergency room and when paying for prescriptions.

HELP CONSUMERS PREPARE:

NOW THAT YOU HAVE A HEALTH PLAN

**WHAT TO DO
BEFORE YOU GO TO THE DOCTOR**

FIRST- THEY SHOULD KNOW THEIR HEALTH PLAN

I GET MY HEALTH PLAN COVERGE FROM:

1. My Employer
2. I Bought It Myself
3. Other

KNOW YOUR HEALTH PLAN – KEY REMINDERS

YOUR INSURANCE CARD GIVES A QUICK REFERENCE TO:

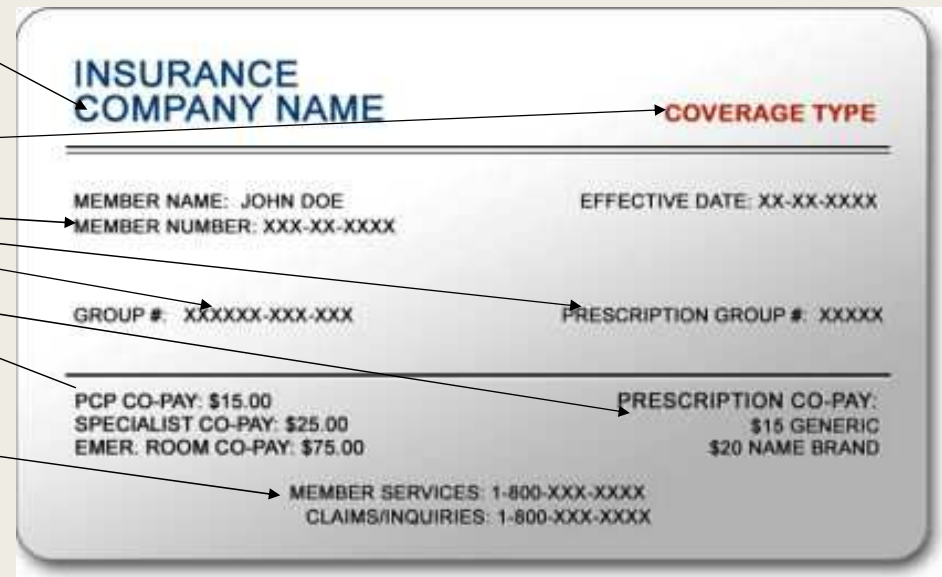
1. The Name of Your Health Plan

2. The Type of Plan You Have

3. Your Policy Numbers

4. What you have to pay out of pocket
for medical care and prescriptions.

5. Health Plan Contact Numbers



Take This Card With You When You See Your Doctor or Pick up Prescriptions.

KNOW YOUR HEALTH PLAN-KEY REMINDERS

WHO IS MY PRIMARY CARE PHYSICIAN?

WRITE DOWN THE NAME, ADDRESS AND
PHONE NUMBER!

KNOW YOUR HEALTH PLAN-KEY REMINDERS

**DOES MY PLAN COVER MENTAL HEALTH
& ADDICTION BENEFITS?**

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KNOW YOUR HEALTH PLAN

- DOES MY PLAN LIMIT COVERAGE OF SOME MENTAL HEALTH & ADDICTION BENEFITS?
- MAKE A LIST OF WHAT'S COVERED.



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KNOW YOUR HEALTH PLAN-GIVE CONSUMERS TIME SAVING
TIPS!

MY PLAN WILL **NOT** COVER THESE
MENTAL HEALTH & ADDICTION
SERVICES:

MAKE A LIST
OF WHAT IS **NOT** COVERED

KNOW YOUR HEALTH PLAN

FOR EXAMPLE: MY PLAN MAY **NOT**
COVER CARE IF I CHOOSE TO SEE A
DOCTOR THAT IS NOT PART OF MY
HEALTH PLAN.

KNOW YOUR HEALTH PLAN

WHO IS MY MENTAL HEALTH &
ADDICTION PROVIDER?

WRITE DOWN THE NAME, ADDRESS AND
PHONE NUMBER!

KNOW YOUR HEALTH PLAN

WHICH HOSPITALS CAN I RECEIVE
CARE AT UNDER MY PLAN?

MAKE A LIST OF HOSPITALS NEAR YOU!

**KNOW YOUR HEALTH PLAN-CONSUMERS MUST BE MINDFUL OF
PREAPPROVALS**

**I CAN'T GET THESE TREATMENTS WITHOUT
GETTING PERMISSION FIRST:**

**MAKE A LIST OF TREATMENTS WHERE
PREAPPROVAL IS REQUIRED!**

KNOW YOUR HEALTH PLAN

FOR EXAMPLE:

YOU MAY NEED TO GET PERMISSION BEFORE
GOING TO AN INTENSIVE OUTPATIENT
TREATMENT PROGRAM IN THE COMMUNITY.

DIRECT CONSUMERS TO
INFORMATION & RESOURCES:
WHAT DO I DO IF I HAVE QUESTIONS
ABOUT MY HEALTH PLAN?

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CONSUMERS HAVE A RIGHT TO ASK FOR
INFORMATION

WRITE DOWN THE CUSTOMER SERVICE
PHONE NUMBER FOR YOUR HEALTH PLAN
IN CASE YOU HAVE QUESTIONS.

THE HEALTH PLAN MUST EXPLAIN THINGS TO CONSUMERS – SOME EXAMPLES

- THE TREATMENT SERVICES THAT YOU HAVE A RIGHT TO.
- THE PROCESS FOR FILING A CLAIM IF YOU ARE DENIED TREATMENT.
- WHAT HAPPENS WHEN YOU FILE A COMPLAINT.
- HOW TO APPEAL IF YOU DON'T GET WHAT YOU HAVE A RIGHT TO.

YOU HAVE A RIGHT TO ASK FOR INFORMATION

- Consumers, Advocates and Providers May Also Contact **Wisconsin's Office of the Commissioner of Insurance** with Questions or to get Information.

PROVIDE PRACTICAL EXAMPLES: ASK FOR WHAT YOU WANT!

If you want to participate in an outpatient program

- Call your Health Plan to find out if the plan will pay for this program.
- Talk to your Mental Health Care & Addiction provider.

ASK FOR WHAT YOU WANT!

FOR EXAMPLE - If you want to use a different medication.

- Talk to your Mental Health Care & Addiction provider.
- Call your Health Plan to find out if the plan will pay for this medication.

CONSUMERS HAVE A RIGHT TO ASK FOR INFORMATION

Additionally, ERISA requires employer group plans to disclose the medical necessity criteria for both MH/SUD and medical/surgical benefits within 30 days of the request, as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL to both behavioral and medical benefits. Moreover, ERISA plans are required to comply with the Department of Labor's (DOL) claims procedure regulations; non-grandfathered group plans and health insurance providers in both group and individuals markets are required to comply with the DOL's rules under the ACA regarding claims and appeals.

CONSUMERS HAVE A RIGHT TO ASK FOR INFORMATION

Disclosure and Transparency

Federal rules and regulations clarify the application of pre-existing federal law disclosure requirements under the Employee Retirement Income Security Act (ERISA) and claims procedure, internal appeals and external review regulations to MHPAEA and its implementation and enforcement.

MHPAEA requires that the **criteria for medical necessity determinations be made available to any potential or current enrollee or contracting provider upon request.** MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available to the plan participant or beneficiary.

PARITY LAW VIOLATIONS

WHAT THEY ARE

AND

WHAT YOU CAN DO ABOUT THEM?

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HELPING CONSUMERS RECOGNIZE THEIR RIGHTS: WHAT IS A VIOLATION?

VIOLATION Simply Defined: A Failure to Do What is Required or Expected under the law.

WHAT IS A VIOLATION OF THE PARITY LAW? HOW TO KNOW!

PARITY is violated when your Health Plan covers
Mental Health & Substance Use Disorder Services

BUT

The plan makes it harder for you to get the same
benefits that you would get when you use the plan
for other Medical treatments.

* *Common violations*

WHAT DOES A VIOLATION LOOK LIKE?

BENEFIT LISTED IN YOUR HEALTH PLAN

- Your Health Plan States that "If you need Specialty Drugs to treat your illness, you are required to pay a 50% co-pay for this medication if you use an in-network provider.

DENIAL OF THE BENEFIT

- You are denied coverage for Specialty Drugs that are **medically necessary** treat your mental health condition or substance use disorder.

WHAT DOES A VIOLATION LOOK LIKE?

BENEFIT LISTED IN YOUR HEALTH PLAN

- Your Health Plan States that "If you need immediate medical attention, you are required to pay a 20% co-pay for an Emergency Room visit if you use an in-network provider.

DENIAL OF THE BENEFIT

- You are told that your visit to the Emergency Room to address a panic attack or suspected overdose will not be covered.

WHAT DOES A CONSUMER DO AFTER THE SERVICE OR BENEFIT IS DENIED?

- RESUBMIT YOUR CLAIM WITH A COPY OF THE DENIAL LETTER
 - THE MISTAKE IN DENYING YOU COVERAGE OR BENEFITS MAY GET CORRECTED.

WHAT DO I DO AFTER THE SERVICE OR BENEFIT IS DENIED?

- CALL YOUR HEALTH PLAN'S CUSTOMER SERVICE LINE AND REPORT THE DENIAL.

- ASK TO SPEAK TO A SUPERVISOR.

YOU MAY BE ABLE TO GET THE ISSUE RESOLVED AND YOUR CLAIM OR BENEFIT GRANTED.

WHAT DO I DO AFTER THE SERVICE OR BENEFIT IS DENIED?

- REQUEST A WRITTEN RESPONSE EXPLAINING THE DENIAL
 - WAIT TO SUBMIT PAYMENT UNTIL YOU GET AN ANSWER.

HOW TO FILE AN APPEAL

Let Consumers Know - What to do when you can't get the services that you have a RIGHT to get.

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WHAT IS AN APPEAL?

- **APPEAL Simply Defined:** A Challenge to a Denial of Coverage by Your Health Plan.

IMPORTANT REMINDERS FOR CONSUMERS:
YOU MUST HAVE THIS INFORMATION WHEN YOU APPEAL

- **DEADLINES**- YOU MUST FILE YOUR APPEAL ON TIME!
 - FIND OUT HOW MUCH TIME YOU HAVE
 - TELL YOUR PROVIDER IF YOU HAVE AN URGENT NEED.
 - YOU MAY HAVE A RIGHT TO A RESPONSE IN 1-3 DAYS IF YOU HAVE AN URGENT NEED.

IMPORTANT:
INFORMATION NEEDED FOR AN APPEAL

- YOUR ORIGINAL BILL
- NAMES OF PEOPLE YOU TALKED TO & THE DATES
- EXPLANATION OF BENEFITS
- EXPLANATION OF YOUR HEALTH PLAN'S MEDICAL NECESSITY CRITERIA.
- DENIAL LETTER

HELPING CONSUMERS DRAFT SUCCESSFUL APPEAL LETTERS: YOUR LETTER SHOULD INCLUDE THESE THINGS

- YOUR NAME ADDRESS & PHONE NUMBER
- YOUR INSURANCE PLAN NUMBER OR SOCIAL SECURITY NUMBER
- YOUR PROVIDER'S NAME AND BILL
- EXPLAIN THE SERVICE THAT YOU REQUESTED
- EXPLANATION OF BENEFITS
- THE SECTION OF YOUR HEALTH PLAN THAT TALKS ABOUT THE BENEFIT YOU ASKED FOR.

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SUCCESSFUL APPEAL LETTERS: YOUR LETTER SHOULD INCLUDE THESE THINGS

- EVIDENCE OF YOUR MEDICAL CONDITION
- NAMES OF PEOPLE YOU TALKED TO ABOUT THE BENEFITS BEING DENIED & THE DATES YOU TALKED TO THEM
- LEGAL REASON THAT YOU HAVE A RIGHT TO THE BENEFIT
- DENIAL LETTER

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7 EXAMPLE APPEAL ISSUES:

1. If a plan excludes or refuses to cover mental health or substance use services based on facility type
2. If a plan excludes or refuses to cover mental health or substance use services based on levels of care
3. If a plan excludes or refuses to cover office-based diagnostic and treatment interventions
4. If a plan has prior authorization or concurrent review requirements for inpatient levels of care
5. If a plan has prior authorization or concurrent review requirements for outpatient psychotherapy
6. If a plan has prior authorization or concurrent review requirements for other outpatient levels of care (PHP, IOP)
7. If a plan refuses to allow a psychiatrist or addiction medicine physician to bill for evaluation and management (E&M) services for mental health or substance use under established E&M CPT codes while permitting other physicians to use these codes for medical/ surgical conditions

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**SELF ADVOCACY - THINGS TO REMEMBER
EQUIPPING CONSUMERS, ADVOCATES AND PROVIDERS WITH
IMPORTANT RESOURCES!**

- A. Terms to Know
- B. Frequently Asked Questions
- C. Model Appeal Letters – Fill In Templates
- D. State and Federal Resource Organizations and Contacts.

