Fair Insurance Coverage:
IT'S THE LAW

Federal law prohibits your private health insurance plan from discriminating against you because you have a mental illness, including a substance use disorder. Coverage for a mental health concern now must be equivalent to coverage for physical health problems, like heart disease, diabetes and cancer.

Under the federal "Mental Health Parity" law:

1. You are entitled to the treatment your physician says is necessary for your mental health or substance use disorder. Your health plan cannot require you to fail first at less-expensive treatments if it does not have the same "fail first" requirement on all other illnesses covered by your plan.

2. With few exceptions your co-payment or co-insurance for your mental health benefit should not be higher than it is for other medical care, and you should have only one deductible and out-of-pocket maximum that covers all of your health care.

3. When you visit a psychiatrist for medication management and for psychotherapy on the same day, you should pay only one co-payment.

4. You should have access to an "in network" mental health provider who:
   - is qualified to treat your condition
   - can see you in a reasonable amounof time at a location accessible from your home.

5. Mental health-related visits or treatment should not require pre-authorization, unless your plan requires pre-authorization for most other medical care.

6. The number of visits or hospital days should not be limited, unless similar limitations apply to most other medical illnesses under your plan.

7. Your health plan should pay even if you don't complete the treatment or a prior recommended course of treatment.

8. Your health plan is required to provide you with a written explanation of:
   - how it evaluated your need for treatment
   - why it denied the claim
   - the basis for its conclusion that the plan complies with federal law.

9. You have the right to appeal your plan's decision about your care or coverage.
   You have the right to appeal the claim with your plan and with an independent review organization. (Check with your state insurance commissioner's office: **www.naic.org/documents/members_membershiplist.pdf**)

10. If you have an out-of-network benefit in your plan and see an out-of-network psychiatrist, the health plan should reimburse you for a portion of the amount you paid for the visit. If the amount you are reimbursed is significantly less than the amount the health plan pays to other doctors who are out-of-network, this may be illegal. You can see what doctors are paid by checking the explanation of benefits you receive from your plan.

If you have concerns about your health plan's compliance with federal law:

- ☑ Call the federal government's Center for Consumer Information and Insurance Oversight (CCIIO) at **877-267-2323 ext. 6-1565** or email its Public Health Interest Group, also part of CCIIO: **phig@cms.hhs.gov**
- ☑ Contact a benefit advisor at the U.S. Department of Labor at **866-444-3272** or **www.askebsa.dol.gov**
- ☑ Call your state insurance commissioner's office (list at **www.naic.org/documents/members_membershiplist.pdf**)

Commissioner: _____ Phone: _____

AMERICAN PSYCHIATRIC ASSOCIATION

Terms of plans differ. This document is not intended to be legal advice. It is intended for public education and awareness only.

7/15

Igualdad de Cobertura Médica:
ES SU DERECHO

La ley federal prohíbe que su plan de seguro médico privado se niegue a proveerle atención médica debido a un trastorno de salud mental o por abuso de sustancias. Ahora, un problema de salud mental se cubre de la misma manera que los problemas relacionados con la salud física como las enfermedades cardíacas, la diabetes y el cáncer.

Según la ley federal de "Igualdad en el Tratamiento de Salud Mental":

1 Puede recibir el tratamiento que su médico diga que es necesario para su salud mental o problema de abuso de sustancias. Su plan médico no puede negarse a pagar su atención ni decirle que primero tiene que probar otros tratamientos menos costosos, a menos que esa sea la regla para las demás enfermedades.

2 Su copago por la atención de salud mental no debe ser más alto del que paga por otros tipos de atención médica. Hay unas cuantas excepciones. Además, le deberán cobrar solo un deducible que incluya su atención de salud tanto física como mental. Deberá tener solo un pago máximo no reembolsable por toda su atención médica.

3 Si acude a un psiquiatra para administrar sus medicamentos y obtener psicoterapia durante la misma consulta, deberá efectuar solo un copago.

4 Deberá tener acceso a un proveedor de salud mental "que participe en la red" que:

- esté calificado para tratar su afección
- pueda atenderlo dentro de un plazo razonable en un lugar cerca de usted.

5 No hay límite en el número de consultas o días de hospitalización para recibir tratamiento de salud mental a menos que, bajo su plan, se impongan límites similares a la mayoría de las demás enfermedades.

6 No hay límite en el número de consultas o días de hospitalización para recibir tratamiento de salud mental a menos que, bajo su plan, se impongan límites similares a la mayoría de las demás enfermedades.

7 Su compañía de seguro médico deberá pagar aunque usted no termine el tratamiento.

8 Su compañía de seguro médico tiene que darle una explicación por escrito de:

- cómo evaluó su necesidad de tratamiento
- por qué le denegó su reclamación de salud mental
- por qué cree que su denegación está en cumplimiento de la ley federal

9 Tiene el derecho de apelar la decisión de su compañía de seguro relacionada con su cobertura. Tiene el derecho de apelar la reclamación ante un árbitro independiente. (Consulte en la oficina del comisionado de seguros de su estado: **www.naic.org/documents/members_membershiplist.pdf**)

10 Si su plan tiene un beneficio de atención fuera de la red y usted consulta con un psiquiatra fuera de la red, su aseguradora deberá reembolsarle parte del monto que pague por la consulta. Si el monto que le reembolsan es mucho menos de lo que su aseguradora paga típicamente por otros médicos fuera de la red, eso podría ser ilegal. Puede ver lo que les pagan a los médicos en la explicación de beneficios que recibe de su plan.

Si tiene inquietudes o preguntas relacionadas con su compañía de seguro y sobre si cumple con la ley federal:

☑ Llame al Center for Consumer Information and Insurance Oversight (CCIIO) [Centro de Información al Consumidor y Supervisión de Seguros] al **877-267-2323, extensión 6-1565** o envíe un correo electrónico al Public Health Interest Group [Grupo de Interés en la Salud Pública], que también es parte del CCIIO: **phig@cms.hhs.gov**

☑ Comuníquese con un asesor de beneficios del US Department of Labor [Departamento del Trabajo de EE. UU.] al **866-444-3272** o al **askebsa.dol.gov**

☑ Llame a la oficina estatal del comisionado de seguros (encontrará una lista en **naic.org/documents/members_membershiplist.pdf**)

Comisionado: _____ Teléfono: _____

Los términos de los planes varían. Este documento no pretende ofrecer asesoramiento legal. Se publica solo para fines de educar e informar al público.

AMERICAN PSYCHIATRIC ASSOCIATION

Which plans does the federal parity law apply to? Here is a List

PLAN	DOES MHPAEA APPLY?
Employer-funded plans with more than 50 insured employees	Yes
Medicaid managed-care plans	Yes
Children's Health Insurance Program plans	Yes
Medicaid Alternative Benefit plans (Medicaid expansion)	Yes
Non-grandfathered small employer plans (less than 51 employees)	Yes*
Non-grandfathered individual market plans	Yes**
Plans offered through the health insurance exchanges	Yes
Federal Employees Health Benefits Plans (FEHBP)	Yes***
TRICARE/DOD plans	No
Medicare plans	No
Veterans Administration	No

* Technically MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly to non-grandfathered small group plans in connection with the Affordable Care Act's essential health benefit (EHB) requirements.

** Non-grandfathered plans are plans that came into existence after the March 23, 2010 passage of the ACA.

*** While the MHPAEA statute does not apply to Federal Employees Health Benefits Program (FEHPB), the Office of Personnel Management has issued carrier letters directing such plans to comply with MHPAEA.

MEDICAID - To find out how the parity law works with MEDICAID versus

PRIVATE INSURANCE, go to this letter found at the Center for Medicare and Medicaid Services:

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/fact-sheet-cms-2333-f.pdf

TOP TEN Common Parity Compliance Issues

Here are examples of problems that come up the most when a Health Plan Includes Coverage for Mental Health and Substance Use Disorders:

1. **You Might Be Able to See Providers That Don't Have a Contract With Your Health Plan.** *IF* plans provide out-of-network coverage under the medical/surgical benefit the plan must provide on par out-of-network coverage under the MH/SUD benefit

2. **What You Have To Pay Must Be Equal** (e.g., deductibles, co-payments, coinsurance or out-of-pocket expenses) imposed on MH/SUD benefits may NOT be more restrictive than those imposed on medical/surgical benefits

3. **Treatment limits Must Be Equal** (e.g., frequency of treatment, number of visits, number of days or similar limits on scope or duration of treatment) imposed on MH/SUD benefits may NOT be more restrictive than those imposed on medical/surgical benefits

4. **You Might Be Able to Get Treatment Outside of Your Local area or State.** Plans cannot require a patient to go to a MH/SUD facility in their own local or state area if the plan allows plan members to go outside of local or state areas for other medical services

5. **Plans can't charge "separate but equal deductibles."** In other words, MH/SUD and medical/surgical benefits must add up together towards the same, combined deductible

6. **You Might Have a Right To Go To Different Kinds of Treatment Facilities.** Plans cannot exclude certain types of MH/SUD facilities or provider types while covering a full range of medical/surgical facilities and provider types

7. **You Have a Right To Know What A Medical Necessity Is Under Your Plan.** Criteria for medical necessity determinations must be made available to any current or potential plan participant, beneficiary or contracted provider (in-network) upon request

8. **You Have a Right To Know Why They Said No.** The reason for any denial of reimbursement or payment must be made available to the participant or beneficiary

9. **Federal Law Must Be Followed.** Where there is a similar state parity law or regulation, the federal parity law serves as the floor. State regulators must enforce at a minimum the federal requirements, along with any additional state requirements

10. **The State of Wisconsin Can Give You More.** State laws that offer more consumer protections than the federal law are NOT preempted.

THE MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

FREQUENTLY ASKED QUESTIONS

1. **What is mental health parity?**

   Parity means that things are the same or equal. Many people were not getting the services that they needed to treat mental illness and substance use addictions. So, the government decided to pass a law to make sure that it will not be harder for people to get care for mental and addiction issues than it is for other medical care.

   The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was passed in 2008 to end this type of health care discrimination. People with mental illness and/or addiction, their families, professionals in the field and employers all worked together to pass the law.

2. **What does the Mental Health Parity and Addiction Equity Act require?**

   If a health care plan covers mental health and addiction care, the plan must provide coverage that is equal to what they provide for other kinds of healthcare like medical and surgical benefits.

3. **Do all health plans have to comply with the parity law?**

   NO. While MHPAEA applies to most employment-based health coverage, some plans are exempt.
   MHPAEA does not apply to small employers who have fewer than 51 employees.
   There is also an increased cost exemption available to plans whose costs increase by more than a specified amount and who follow guidance issued by the Departments.
   Additionally, plans for State and local government employees that are self-insured may opt-out of MHPAEA's requirements if certain administrative steps are taken (such as sending notice to enrollees).
   Finally, MHPAEA does not apply to retiree-only plans.

4. **Can a health plan define mental health coverage as ONLY inpatient care benefits?**

   No. The Departments regulations set forth six classifications of benefits:
   1) Inpatient, in-network
   2) Inpatient, out-of-network
   3) Outpatient, in-network
   4) Outpatient, out-of-network
   5) Emergency care; and
   6) Prescription drugs.

   If a plan covers mental health or substance use disorder benefits in one of the six classifications, the plan must provide coverage in all of the classifications in which medical/surgical benefits are available. Therefore, a plan that provides medical/surgical benefits on an outpatient basis may not limit mental health or substance use disorder benefits to inpatient care only.

5. **Does the parity law apply to Residential Treatment?**

YES. If mental health and substance use disorder treatment is part of your health plan, mental health parity applies to medically necessary mental health and substance abuse treatment:

Inpatient and outpatient treatment
Residential treatment.

6. **What information do I have a right to when a service is denied?**

MHPAEA requires that plans make certain information available with respect to mental health and substance use disorder benefits.
Insurers typically make decisions to cover or deny coverage for specific mental health and substance use disorder services based on whether that service is "medically necessary" for the patient. These insurers must share the criteria that they use to make these medical necessity determinations with any current or potential participant, beneficiary, or contracting provider upon request.
MHPAEA also provides that insurers must explain the reason for any denial of reimbursement or payment for services for mental health and substance use disorder benefits to the participant or beneficiary upon request, or as otherwise required.

7. **What do I do if my plan violates the law?**

If you have concerns about your plan's compliance with MHPAEA, you can contact the Federal government or your State Department of Insurance. You may contact the Department of Labor at 1-866-444-3272 or on the web at:
http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. You may also contact the Department of HHS at 1-877-267-2323 ext. 61565 or at phig@cms.hhs.gov or your State Department of Insurance:

Office of the Commissioner of Insurance
125 South Webster Street
Madison, Wisconsin 53703-3474
(608) 266-3585, Madison;
(800) 236-8517, statewide;
711 (TDD) (ask for 608-266-3586)
Hours: Monday - Friday 7:45 a.m. - 4:30 p.m. (except for legal holidays)

8. **I still have questions, where can I get information?**

If you have additional questions regarding the
Federal Mental Health Parity and Addiction Equity
Act, please contact:
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attn: CMS-4137-NC
P.O. Box 8017
Baltimore, MD 21244-8010
1-800-633-4227
1-877-486-2048 TTY www.cms.gov

Checklist for Picking a Health Plan

The following checklist can help you evaluate your current health plan, as well as others you're considering. Compare the services offered and the cost of each plan. Then choose the plan that best meets your family's needs.

Financial Considerations

What is the monthly premium? _____

What is the deductible per year? _____

How much is the co-payment for each time of service? _____

What is the co-insurance percentage? _____

What is my expected cost for a typical year? _____

Choosing a Provider

Given the plan's participating providers, who would you chose for:

A primary care physician_____

Specialists_____

An urgent care center_____

A hospital_____

Evaluating Your Coverage

Which of the following coverage is offered and what do you think about it?

Next to each service, give the service offered a rating:

GOOD if what the plan offers will meet your need

FAIR if the plan coverage only pays for part of what you need

POOR if the service is not included in the plan or if the coverage in this area will not meet your needs:

_____ Psychiatric care

_____ Drug and alcohol treatment

_____ Prescription drugs

_____ Rental or purchase of medical equipment (such as crutches or a wheelchair)

_____ Treatment of chronic conditions

_____ Treatment of pre-existing conditions

_____ Surgical care

_____ Emergency room visits

_____ Inpatient hospital services

_____ Consultations with specialists

_____ Family planning services

_____ Maternity services, including prenatal care and delivery

_____ Newborn care

_____ X-ray and laboratory services

_____ Rehabilitation and habilitation services, including physical, speech and occupational therapy

_____ Well-child care

_____ Annual physical exams

_____ Immunizations or allergy injections

_____ Home health care or services of a licensed private duty nurse

_____ Hospice care for the terminally ill

_____ Care delivered at a skilled nursing facility instead of a hospital

Health Plan Coverage Checklist

The Name of my Health Insurance Plan is _____

If I have a question or a problem, I can reach my plan at: ( ) _____

I get my health plan coverage through:

Check the Box that best describes your plan – ASK if you do not know by calling customer service.

O My employer: My plan is a fully-insured plan; any plan denials are eligible for state external review

O My plan is a self-insured plan; any denials are NOT eligible for state external review

O My employer employs more than 50 people

O A policy I bought myself

O An association-sponsored policy (such as a trade or educational organization)

O Other _____

My health plan: Check the Box that best describes your plan – ASK if you do not know by calling customer service.

O Covers mental health and addiction benefits

O Manages mental health and addiction benefits directly

O Contracts with an outside entity (e.g., Managed Behavioral Health Organization (MBHO)) to manage them

My primary care physician is: _____

My physician's phone number: _____

My mental health/addiction provider is:

My mental health/addiction provider's phone number: ( ) _____

I need prior authorization (ask before getting these services):

O I need a referral from my primary care physician for

O Lab and x-ray tests

O Other specialist visits

O Other – Write them here _____

OR – If you don't need to get permission – check the box below:

O I do not need a referral from my primary care physician

Benefit Coverage Checklist: Exclusions and Limitations

Your Health Plan will NOT cover certain services.
Depending on your type of health insurance plan, you may have a Summary of Benefits and Coverage, a Summary Plan Description, Evidence or Certificate of Coverage and a Benefits Booklet.

Make sure that you read about the Exclusions, Limitations and Non-Covered sections of your benefit coverage. Then fill in this list:

My health plan will not pay for or limits the following mental health/substance use disorder services: Write Them Down!

1.
2.
3.

List Other Services that are NOT covered here:

_____
_____
_____

If I have in-network benefits only, is my provider in my health plan network? Circle **YES** or **NO**

My plan will cover services at the following hospitals:

1.
2.
3.

Other Clinics and Hospitals that my plan will cover services:

_____
_____

What should I do if I need care while I am outside my plan's service area?
For non-urgent care, I should call:

Provider:

Phone:

For urgent care, I should call:

Provider:

Phone:

Documents and Information that You Have a Right To.

These are specific documents and information that health plans must give to provide to consumers (and providers on behalf of consumers), if requested.

These documents include:

- **What's In Your Plan?** - You can get A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;

- **What is the Rule or Standard?** - The specific plan language regarding the imposition of the "non-quantitative treatment limit" (such as a preauthorization requirement);

- **You Have A Right to Know How The Insurance Company Came to the Conclusion that Limits Apply to the treatment or service that you wanted**- The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;

- **Was the Rule Applied Equally to Obey the Parity Law?** - Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;

- **Why the Limit applies to the treatment or service that you wanted** - The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and

- Did The Insurance Company Make Sure that the Parity Law was not Violated? - You have a right to see any analyses performed by the plan as to how the NQTL complies with MHPAEA.

Checklist – Things You Need For Your Appeal of a Denial of Treatment or Benefits by Your Health Plan

Get this information *Before* you write your appeal letter:

1. **Deadlines – Find out how much time you have to file your appeal.**
2. **Your Ongoing Bill**
3. **Explanation of Benefits**
4. **Explanation of Your Health Plan's Medical Necessity Criteria**
5. **The Letter Denying the treatment or service that you asked for.**
6. **The Names of People that you talked to and the dates:**

I SPOKE WITH: Name	DATE

YOUR APPEAL LETTER – A Successful Appeal Letter will include:

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

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

Appeal Letter Sample: Medical Necessity Denial for Inpatient Services – Use this as a GUIDE – your letter must contain information about your claim.

Note: Highlights prior authorization or concurrent review requirements or inpatient services.

[Insert Date]
[If URGENT, then indicate URGENT APPEAL]
[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]

[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:
I have been a member of your plan since [date] and am now writing to appeal your decision to deny coverage for [state the name of the specific treatment or service denied AND if it is urgently needed to prevent harm or the inability to regain maximal function]. It is my understanding based on your letter dated [insert date of denial] that this [treatment or service] has been denied because: [Quote the specific reason given in the denial letter].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications. I have also attached a rationale for why I am entitled to this service under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). [If the treatment is urgent, then the treating professional should indicate so in the attached letter.]
I also hereby request that you: 1) provide me with a copy of the SBC and/or SPD and complete benefit plan booklet for both the medical/surgical and mental health/substance use disorder benefits within 30 days; 2) explain the specific plan provisions you are relying upon to deny coverage of these services; and 3) provide me with plan documents under which the plan is established or operated, with information on the processes, strategies, evidentiary standards and other factors used to develop and apply preauthorization and concurrent review requirements for inpatient services under the behavioral health benefit; and 4) explain how that is comparable to and applied no more stringently than the development and application of pre-authorization and concurrent review requirements for similar inpatient service categories under the medical/surgical benefit. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,

[Insert your name]
Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]
Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

*** COPY the following Analysis from the Parity Implementation Coalition and attach it to your denial of inpatient services appeal letter. It provides SUPPORT for your appeal.**

The Parity Implementation Coalition has adopted the following position statement with respect to any covered mental health and substance use disorders requiring **prior authorization or concurrent reviews for inpatient levels of care.**

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")s requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

The statute defines "treatment limitations" as "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. non-numeric). The regulations create six benefits classifications for purposes of applying the parity requirements: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.
Both the Interim Final Regulations and the Final Regulations expressly identify "preauthorization," "concurrent review," "case management," and "utilization review" as "medical management techniques" used by plans to assess medical necessity. Although health plans may condition both mental health/ substance use disorder and medical/surgical benefits on medical necessity, the regulations nonetheless require that any processes and strategies used to assess medical necessity for mental health/substance use disorder care be comparable to and applied no more stringently than those used to assess the medical necessity of medical/surgical care. Thus, health plans may not require preauthorization only for inpatient admissions for mental health or substance use disorders without requiring the same for medical/surgical care within the corresponding classifications.

Additionally, as highlighted by the Final Regulations, health plans may not apply concurrent reviews more stringently for inpatient mental health or substance use care than for medical/surgical care within the corresponding classifications:

> Facts. A plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan.

Conclusion. In this [e]xample, the plan violates the rules . . . because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/ surgical benefits.

How to File a Complaint

After you have contacted your insurance company and have gone through the internal and external appeal processes, you may file a formal grievance with the **State or Federal** agency that oversees your health plan.

Here is how to file a complaint:

1. Identify your type of insurance coverage from the chart below
2. Complete your complaint letter using the templates (TEMPLATES ARE ATTACHED)
3. Submit to the responsible agency

Step 1: **Identify your type of insurance coverage from the list below**	Step 2: **Complete your complaint letter using the templates**	Step 3: **Submit to the responsible agency**
Insurance plans (plans purchased by employers, or by individuals)	Template complaint letter to state insurance commissioner o Download Template	State insurance commissioner. Find your commissioner.
Employer pays for coverage (Self-funded plan)	Template complaint letter to Department of Labor o Download Template	U.S. Department of Labor
Insurance through state/local government employers	Template complaint letter to Department of Health and Human Services o Download Template	U.S. Department of Health and Human Services

Find the above Information at the American Psychiatric Association's web page:
https://psychiatry.org/psychiatrists/practice/parity

Template Complaint Letter #1 – Employer/individual purchase

- Use this template if your health insurance plan is purchased by your employer or by you individually
- Send the letter to your state insurance commissioner
  Wisconsin Office of the Commissioner of Insurance
  125 South Webster Street
  Madison, Wisconsin 53703-3474

State of Wisconsin Insurance Commissioner

Today's date:

My name is: _____. My phone number is: _____.
My address is: _____.

I am a patient of: _____.

I have _____ plan with _____ insurance company in the city of _____, state of _____.

Check One:

_____ My employer (or family member's employer), _____, purchased this insurance coverage for me;

_____ I (or a family member) purchased this insurance on the individual market; or

_____I (or a family member) purchased this insurance through the health insurance exchange.

I believe I have been discriminated against in violation of the Federal Mental Health Parity and Addiction Equity Act because I have:

___been unable to find an in-network psychiatrist who is qualified to treat my condition or can see me in a reasonable amount of time at a location near me

___ been required to get prior authorization for psychiatric treatment (visits or drugs) but not for other medical care

___ been limited to ___ number of visits to my psychiatrist or hospital days

___my co-payment for psychiatric visits is higher than it is for other medical care

___been told I my psychiatric care is not covered or I must fail other treatments first before it will be covered.

I request that you investigate this matter as soon as possible. Please call me at the number above to discuss and initiate this investigation.

Template Complaint Letter #1 – Employer/individual purchase for Substance Use issues

State of Wisconsin Insurance Commissioner

Today's date:

My name is: _____. My phone number is: _____.
My address is: _____.

I am a patient of: _____.

I have _____ plan with _____ insurance company in the city of _____, state of _____.

Check One:

____ My employer (or family member's employer), _____, purchased this insurance coverage for me;

_____ I (or a family member) purchased this insurance on the individual market; or

_____I (or a family member) purchased this insurance through the health insurance exchange.

I believe I have been discriminated against in violation of the Federal Mental Health Parity and Addiction Equity Act because I have:

___been unable to find an in-network addiction care provider who is qualified to treat my condition or can see me in a reasonable amount of time at a location near me

___ been required to get prior authorization for substance use disorder treatment (visits or drugs) but not for other medical care

___ been limited to ___ number of visits to my addiction care provider or hospital days

___my co-payment for addiction care visits is higher than it is for other medical care

___been told I my substance use disorder care is not covered or I must fail other treatments first before it will be covered.

I request that you investigate this matter as soon as possible. Please call me at the number above to discuss and initiate this investigation.

PARITY GLOSSARY

TERMS YOU NEED TO KNOW

A

Appeals Process - When a person challenges an insurance claim that has been denied. Usually, each insurance company has its own process.

B

Behavioral Health -Mental health and Substance Use Disorder (addiction)

Benefits Representative -If you get your insurance through your employer, this is the person at your workplace who can explain your insurance plan to you. Some small employers (less than 51 employees) may not have a benefits representative.

C

Classification of Benefits - Federal parity regulations created six different categories of insurance benefits for all behavioral health services: inpatient in-network , inpatient out-of-network , outpatient in-network , outpatient out-of-network , emergency care, and prescription drugs. All services fall into one of these categories.

Coinsurance -Money that a person with insurance has to pay for services, after a deductible has been met. Coinsurance is a percentage of the overall cost of the service. So if the service cost $100 and your coinsurance rate is 25%, you will pay $25 for that service and the insurer will pay $75.

Comprehensive Parity Law -A law that requires insurance plans to provide coverage for all behavioral health conditions and provide that coverage at the same terms and conditions as coverage for other medical care.

Copayment - Money that a person with insurance has to pay for services after a deductible has been met. A copayment is a flat dollar amount, like $20 per visit, but may vary by type of doctor you see (for example a specialist may have a higher dollar amount.)

D

Deductible - The money a person must pay on her own, or out-of-pocket , before the insurance company starts to pay for care.

Disclosure - Information an insurer has to tell you about your plan and what rules and laws apply to your plan.

E

ERISA - The federal Employee Retirement Income Security Act. ERISA sets minimum standards for pension and health insurance plans offered by large employers. ERISA also sets health insurance standards for employers who choose to self insure (employers who use their own money to pay all of the claims for their employees' health care.) Self-insured health insurance plans are often called ERISA plans.

Essential Health Benefits (EHB) - The Affordable Care Act requires health insurance plans to include coverage for 10 different categories of care. Mental health and substance use disorder care is one of the categories.

Exclusions - Specific services an insurance plan will not cover.

Expedited Appeals Process - This is an appeal for a denial of coverage that insurance plans must respond to quickly; usually within 24-48 hours.

Explanation of Benefits - A letter sent from the health insurance company to an insured member listing services that were billed by a healthcare provider, how those charges were processed, and how much the patient may have to pay.

External Review - One of the last steps in the appeal process . A person may ask for an external review once she has completed all of the insurance plan's appeal processes. Usually a group of people that aren't part of the insurance company will review everything and decide whether or not the insurance company must pay for treatment. External reviews are usually done by an Independent Review Organization .

F

Fail-First Protocol - A requirement that a patient try a less expensive treatment first before she can get approval for the treatment her provider orders. For example, an insurance plan may not pay for a brand name medication until a person does not improve using a generic medication . This is also known as step therapy .

Federal Parity Law - The Mental Health Parity and Addiction Equity Act (MHPAEA). This is a federal law that requires many insurance plans that offer behavioral health coverage to provide that coverage with the same terms and conditions as other medical coverage. The law doesn't require insurance plans to cover behavioral health services, but if they do, it has to be equal with other medical coverage. There are also state parity laws .

G

Grandfathered Plan - A health insurance plan that was created before 3/23/2010. These plans do not have to comply with all of the requirements of the Affordable Care Act and do not have to comply with the Federal Parity Law.

Grievance Appeal - A complaint by a person about an insurance company's coverage of his/her care.

I

Individual Plans - These are insurance plans that people can purchase for themselves. Usually these plans are for people who don't get insurance through their employer.

In-network - Providers and healthcare facilities that are part of a health insurance plan's network. Patients usually pay less when using an in-network provider or facility.

Inpatient Care - Services given in a hospital after admission with a written doctor's order.

Intensive Outpatient Care - A type of outpatient treatment that is more thorough than usual outpatient care but not as extensive as partial hospitalization. Intensive outpatient care is often used for people who have substance use disorders or eating disorders.

L

Lifetime Limits - The highest number of inpatient days or outpatient visits an insurance plan will pay for health services over the entire time you are on that plan.

Lifetime Maximum - The highest dollar amount an insurance plan will pay for your care over the entire amount of time you are on that plan.

M

Medically Necessary - Any health-care services or prescription medications that are needed to treat a condition and that meet accepted standards of medicine. This is closely related to medical necessity .

Medical Necessity - A set of standards health insurance companies use to decide if they will pay for health care services. A service meets these standards if it's considered an accepted treatment for the specific diagnosis and it's the least expensive option that will help the person recover.

Medical Necessity Appeal - An appeal filed when the health plan has denied or reduced the level of care based on what is medically necessary . Also called a Utilization Management (UM) Appeal.

N

Non-Grandfathered Plan - These are health insurance plans created after 3/23/2010. Most of these plans must comply with the Affordable Care Act and the Federal Parity Law. All of these plans issued after 10/1/2016 will have to comply with the Affordable Care act and the Federal Parity Law.

Non-Quantitative Treatment Limitation (NQTL) - A limitation that can't be measured with numbers. Examples include geographic restrictions, facility type restrictions, utilization management , prior authorization , fail-first protocol , prescription medication formularies , etc.

O

Out-of-Network - Providers and healthcare facilities that are not part of a health plan's contracted network and can set their own prices for the services they provide. Insurance plans may cover some of the costs for services given out-of-network or they may not pay for anything.

Out-of-Pocket - Health care costs a person has to pay on his own.

Outpatient Care - Treatment given to a person who can go home after care without being admitted in a hospital or treatment facility.

P

Parity - The concept that insurance plans should cover services for behavioral health conditions the same way they cover other medical conditions, like diabetes or heart disease. Parity is about fairness and equal rights for people who need behavioral health services.

Parity Appeal - An appeal filed with an insurance plan when the plan's decision to deny or restrict coverage may be in violation of the Federal Parity Law or state parity laws.

Premium - A health insurance premium is the monthly fee that is paid to an insurance company or health plan to provide health coverage.

This health care coverage typically includes paying for health-related services such as doctor visits, hospitalizations, prescriptions, and medications. In short, the premium is the payment that you make to your health care provider annually that keeps coverage fully active.

If a premium is not fully paid, a health care provider may suspend of cancel services until the amount is paid in full.

Prior Authorization (Pre-Certification) - This is when a patient needs to get pre-approved for coverage of a treatment or medication. An insurance plan may not pay for care if the patient's condition does not meet certain standards. The insurance company usually won't approve a drug or service until the patient's provider gives notes and/or lab results describing the patient's condition and treatment history.

Q

Qualified Health Plan - An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Quantitative Treatment Limitation - A limitation on treatment that can be measured with numbers. Examples include: outpatient visit limitations, inpatient day limits, coinsurance or copayments , deductibles and annual caps on reimbursement.

R

Residential Treatment - This is treatment delivered in a setting in which the patient is in the treating facility 24 hours a day, 7 days a week.

S

Standard of Care - A clinically accepted treatment process that a provider should follow for a patient's care. This is often how insurance companies decide if they will pay for services during medical necessity reviews.

State Parity Laws - State laws that may require insurance plans to provide behavioral health coverage at the same terms and conditions as other medical coverage. State parity laws can be very different in terms of how much they require of insurance plans and to which plans they apply. Some state parity laws require insurance plans to provide more coverage than the Federal Parity Law , and some state laws do not. Whenever both a state parity law and the Federal Parity Law apply to the same insurance plan, the insurance plan has to abide by the law that requires more coverage.

Substance Use Disorder - Substance use disorders can refer to drug and alcohol use or drug and alcohol dependence.

T

Treatment Limitations - Any way an insurance plan tries to limit how much a patient uses medical services.

U

Usual, Customary, and Reasonable (UCR) Charge -The term used by insurance companies to justify the amount of money they will pay for specific health care services.

TO SEE THE COMPLETE PARITY GLOSSARY – GO TO

https://www.paritytrack.org/know-your-rights/glossary