Accessing Behavioral Health Services: Behavioral Health in Medicaid Managed Care & Using Parity Laws

Thursday, September 15, 2016

Albany Marriott
Albany, NY

CLE Course Materials and NotePad®

Complete course materials distributed in electronic format online in advance of the program.

Sponsored by the

New York State Bar Association and the Committee on Legal Aid

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New York State Bar Association

Lawyer Assistance Program 800.255.0569

NYSBA

Q. What is LAP?

A. The Lawyer Assistance Program is a program of the New York State Bar Association established to help attorneys, judges, and law students in New York State (NYSBA members and non-members) who are affected by alcoholism, drug abuse, gambling, depression, other mental health issues, or debilitating stress.

Q. What services does LAP provide?

A. Services are **free** and include:

- Early identification of impairment
- Intervention and motivation to seek help
- Assessment, evaluation and development of an appropriate treatment plan
- Referral to community resources, self-help groups, inpatient treatment, outpatient counseling, and rehabilitation services
- Referral to a trained peer assistant – attorneys who have faced their own difficulties and volunteer to assist a struggling colleague by providing support, understanding, guidance, and good listening
- Information and consultation for those (family, firm, and judges) concerned about an attorney
- Training programs on recognizing, preventing, and dealing with addiction, stress, depression, and other mental health issues

Q. Are LAP services confidential?

A. Absolutely, this wouldn't work any other way. In fact your confidentiality is guaranteed and protected under Section 499 of the Judiciary Law. Confidentiality is the hallmark of the program and the reason it has remained viable for almost 20 years.

Judiciary Law Section 499 Lawyer Assistance Committees Chapter 327 of the Laws of 1993

Confidential information privileged. The confidential relations and communications between a member or authorized agent of a lawyer assistance committee sponsored by a state or local bar association and any person, firm or corporation communicating with such a committee, its members or authorized agents shall be deemed to be privileged on the same basis as those provided by law between attorney and client. Such privileges may be waived only by the person, firm or corporation who has furnished information to the committee.

Q. How do I access LAP services?

A. LAP services are accessed voluntarily by calling **800.255.0569** or connecting to our website **www.nysba.org/lap**

Q. What can I expect when I contact LAP?

A. You can expect to speak to a Lawyer Assistance professional who has extensive experience with the issues and with the lawyer population. You can expect the undivided attention you deserve to share what's on your mind and to explore options for addressing your concerns. You will receive referrals, suggestions, and support. The LAP professional will ask your permission to check in with you in the weeks following your initial call to the LAP office.

Q. Can I expect resolution of my problem?

A. The LAP instills hope through the peer assistant volunteers, many of whom have triumphed over their own significant personal problems. Also there is evidence that appropriate treatment and support is effective in most cases of mental health problems. For example, a combination of medication and therapy effectively treats depression in 85% of the cases.

Personal Inventory

Personal problems such as alcoholism, substance abuse, depression and stress affect one's ability to practice law. Take time to review the following questions and consider whether you or a colleague would benefit from the available Lawyer Assistance Program services. If you answer "yes" to any of these questions, you may need help.

1. **Are my associates, clients or family saying that my behavior has changed or that I don't seem myself?**
2. **Is it difficult for me to maintain a routine and stay on top of responsibilities?**
3. **Have I experienced memory problems or an inability to concentrate?**
4. **Am I having difficulty managing emotions such as anger and sadness?**
5. **Have I missed appointments or appearances or failed to return phone calls? Am I keeping up with correspondence?**
6. **Have my sleeping and eating habits changed?**
7. **Am I experiencing a pattern of relationship problems with significant people in my life (spouse/parent, children, partners/associates)?**
8. **Does my family have a history of alcoholism, substance abuse or depression?**
9. **Do I drink or take drugs to deal with my problems?**
10. **In the last few months, have I had more drinks or drugs than I intended, or felt that I should cut back or quit, but could not?**
11. **Is gambling making me careless of my financial responsibilities?**
12. **Do I feel so stressed, burned out and depressed that I have thoughts of suicide?**

There Is Hope

CONTACT LAP TODAY FOR FREE CONFIDENTIAL ASSISTANCE AND SUPPORT

The sooner the better!

Patricia Spataro, LAP Director

1.800.255.0569

New York State Bar Association

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Speakers, moderators, panelists and attendees are required to complete attendance verification forms in order to receive MCLE credit for programs. Faculty members and attendees: please complete, sign and return this form along with your evaluation, to the registration staff **before you leave** the program.

You MUST turn in this form at the end of the program for your MCLE credit.

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Name:

(Please print)

I certify that I was present for the entire presentation of this program

Signature: Date:

Speaking Credit: In order to obtain MCLE credit for speaking at today's program, please complete and return this form to the registration staff before you leave. **Speakers** and **Panelists** receive three (3) MCLE credits for each 50 minutes of presenting or participating on a panel. **Moderators** earn one (1) MCLE credit for each 50 minutes moderating a panel segment. Faculty members receive regular MCLE credit for attending other portions of the program.

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Program Name:

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Program Date:

1. What is your overall evaluation of this program? Please include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional Comments____

____

2. Please rate each Speaker's Presentation based on **CONTENT** and **ABILITY** and include any additional comments.

	CONTENT				ABILITY			
	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor
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Additional comments (CONTENT)

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Additional comments (ABILITY)

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3. Please rate the program materials and include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional comments

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4. Do you think any portions of the program should be **EXPANDED** or **SHORTENED**? Please include any additional comments.
☐ Yes – Expanded ☐ Yes – Shortened ☐ No – Fine as is

Additional comments

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5. Please rate the following aspects of the program: **REGISTRATION**; **ORGANIZATION**; **ADMINISTRATION**; **MEETING SITE** (if applicable), and include any additional comments.

	Please rate the following:				
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Registration	☐	☐	☐	☐	☐
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Additional comments

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6. How did you learn about this program?
☐ Ad in legal publication ☐ NYSBA web site ☐ Brochure or Postcard
☐ Social Media (Facebook / Google) ☐ Email ☐ Word of mouth

7. Please give us your suggestions for new programs or topics you would like to see offered

_____

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NYSBA
NEW YORK STATE BAR ASSOCIATION
One Elk Street, Albany, NY 12207
Phone: 518-463-3200 | Secure Fax: 518.463.5993

Description

This session will cover two emerging mechanisms for accessing more comprehensive behavioral health (mental health and substance use disorder) services in public and commercial insurance. The first part will introduce participants to the carve-in of behavioral health services into Medicaid managed care including the new Health and Recovery Plans which are intended to better coordinate behavioral health and medical services, and provide an opportunity for access to behavioral health services and supports that have not been previously available in Medicaid. The second part of the training will cover the basics of the Mental Health Parity and Addiction Equity Act of 2008 ("federal parity law") and its application in private insurance, Medicaid and Child Health Plus.

Accessing Behavioral Health Services: Behavioral Health in Medicaid Managed Care & Using Parity Laws
September 15th
3:00 PM - 4:15 PM
1.5 MCLE credits in Areas of Professional Practice for both experienced and newly-admitted attorneys.

Outline

I. Behavioral Health in Medicaid Managed Care
   A. Overview
   B. Who is involved in the behavioral health transition to managed care?
   C. What is changing and for whom?
      1. Behavioral health care in
         a. Accessing services and Case Management
      2. HARPs
   D. HARPs
      1. Eligibility
      2. Enrollment
      3. Enhanced services
         a. Care coordination
         b. Home and Community Based Services
            i. Available Services
            ii. Assessments
            iii. Plan of Care
            iv. Appeal rights
   E. Network Adequacy
   F. Advocacy Concerns and Issues
II. Using Parity Laws (Karla Lopez, Legal Action Center)
   A. What is the Federal Parity Law
      1. Overview
      2. Who Must Comply?
      3. What Does It Require?
      4. The Details
   B. How to Enforce Federal Parity Rights
      1. Transparency Requirements
      2. Appeals
      3. Government Enforcement
      4. Lawsuit
   C. Relevant NYS Laws
      1. Insurance Coverage for Court-Ordered Treatment
      2. 2014 Opioid Legislation

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Power Point 1

Behavioral Health in Medicaid Managed Care

Behavioral Health in Medicaid Managed Care

NYSBA Partnership Conference, September 15, 2016

Amy E. Lowenstein
Senior Attorney
Empire Justice Center

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Agenda

- Background
- Behavioral Health Carve-In To Managed Care
- Health And Recovery Plans
- Home and Community Based Services
- Accessing Services

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BACKGROUND

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The Acronyms

- **BH** – Behavioral Health
- **FFS** – Fee-for-service Medicaid
- **HARP** – Health and Recovery Plan
- **HCBS** – Home & Community Based Services
- **HIV SNP** – HIV Special Needs Plan
- **MMC** – Medicaid Managed Care
- **SMI** – Serious Mental Illness
- **SUD** – Substance Use Disorder

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The Players

- NYS Department of Health (DOH)
- NYS Office of Mental Health (OMH)
- NYS Office of Alcohol and Substance Abuse Services (OASAS)
- Health Homes
- Mainstream Medicaid Managed Care
- HIV SNPs (NYC)
- Health and Recovery Plans (HARPs)
- Consumers!!

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What are Behavioral Health Services?

- Behavioral Health (BH) services are services for treatment of mental illness and substance use disorders.
- Services are generally licensed or certified by OMH or OASAS

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BEHAVIORAL HEALTH CARVE-IN TO MANAGED CARE

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The Managed Care BH Service Carve-In :

Before Carve-In	After Carve-In
• MMC & HIV SNP members got some Medicaid BH services FFS and some through managed care • Whether particular services were FFS or managed care depended on Medicaid eligibility category (SSI/SSI related vs non-SSI related)	• All BH services part of MMC benefit, HIV SNP and HARP package for all members • EXCEPTION – rehabilitation supports for people in OMH Community Residence are not yet carved in – still FFS

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Whose BH Benefits Are Now Carved-In to Managed Care?

- BH Carve-in is only for people eligible for and enrolled in MMC, HARP or HIV SNP.
- BH Carve-in is currently only for adults.
- All others continue to get Medicaid BH services through FFS, e.g.:
  - Dual eligibles (on Medicaid & Medicare)
  - Spenddown
  - Have third party health insurance
  - Children (Carve-in starts in 2017)

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What Changed? For Whom?

	Pre Carve-In		Post Carve-in
BH Service	**SSI related MMC enrollees**	**Other MMC enrollees**	**All MMC Enrollees**
Chemical Dependency Outpatient Clinic & OTP (OASAS)	FFS	FFS	MMC
CDT (OMH)	FFS	FFS	MMC
Partial Hospitalization (OMH)	FFS	FFS	MMC
PROS (OMH)	FFS	FFS	MMC
ACT (OMH)	FFS	FFS	MMC
Rehab Services for OASAS residential	FFS	FFS	MMC

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What Changed? For Whom?

	Pre Carve-In		Post Carve-In
BH Service	**SSI related MMC enrollees**	**Other MMC enrollees**	**All MMC Enrollees**
Medically supervised outpatient withdrawal services (OASAS)	MMC	MMC	MMC
Health Home	MMC	MMC	MMC
Inpatient Hosp Detox (OASAS)	MMC	MMC	MMC
Medically supervised inpatient detox (OASAS(	MMC	MMC	MMC

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What Changed? For Whom?

	Pre Carve-In		Post Carve-In
BH Service	**SSI related MMC enrollees**	**Other MMC enrollees**	**All MMC Enrollees**
Outpatient clinic (OMH)	FFS	MMC	MMC
CPEP (OMH)	FFS	MMC	MMC
OASAS inpatient	FFS	MMC	MMC
OMH inpatient	FFS	MMC	MMC
Rehab services for OMH residential	FFS	FFS	FFS

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Provision of BH Services through Managed Care

- MMCs HARPs and HIV SNPs
  - Must offer all State Plan BH services
  - Must meet specific standards to be qualified to managed the BH benefits
    - Option to manage benefit directly or by subcontracting with a behavioral health organization that meets qualifications
- HIV SNPs – additionally provide all HCBS services
- HARPs – additionally provide enhanced services and supports and all HCBS services

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HEALTH AND RECOVERY PLANS

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What is a HARP?

- New kind of managed care plan for people with significant behavioral health issues
- Provides enhanced case management
- Members may also be eligible for HCBS services that are not traditionally available in Medicaid

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HARP Eligibility

- Eligible for MMC enrollment;
- Age 21+;
- Not enrolled in any OPWDD program;
- SMI/SUD Diagnosis; and
- HARP Risk Factor
  - Based on past utilization of behavioral health services

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HARP Enrollment

- MMC members identified as HARP eligible
  - DOH identifies on quarterly basis based on Medicaid behavioral health usage data
  - Process is also being developed for provider referrals of individuals for HARP

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HARP Enrolment (cont'd)

- Identified Members notified of HARP eligibility and enrollment opportunity
  - MMC members whose MMC has an affiliated HARP → passively enrolled into sister HARP unless opt out or choose different HARP
  - MMC members whose MMC has no affiliate HARP → receive notice of availability of HARP. Must affirmatively enroll
  - HIV SNP members notified of HARP, informed that HIV SNPs offer the same benefits

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HARP Enrolment (cont'd)

- HARP enrollees are subject to lock-in
  - Within first 90 days of enrollment may disenroll to MMC or choose different HARP
  - After 90 days → lock in for 9 months, after which may choose a new HARP or MMC

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HARP Benefits

- Same benefits as in MMC

+ Enhanced Care Management

+ Access to HCBS

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Care Management

- HARP assigns member to a Health Home (option to choose different health home)
- Health Home evaluates for HCBS eligibility
- Health Home creates person-centered care plan
- Option to choose non-health home care management (except for HCBS evaluation)

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HOME AND COMMUNITY BASED SERVICES

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HCBS

"A range of community based supports, rehabilitation and treatment services … designed to allow individuals to gain the motivation, functional skills and personal improvement to be fully integrated into communities."

Health and Recovery Plan Adult Behavioral Health Home and Community Based Services Provider Manual

- Previously not available to adult population through Medicaid.
- Do not have to meet institutional level of care as would under a 1915(c) waiver
- Assessment for HCBS is annual

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HCBS Services

Tier 1 HCBS

- Empowerment Services - Peer Supports
- Individual Employment Support Services
  - Pre-vocational Services
  - Transitional Employment
  - Intensive Supported Employment
  - Ongoing Supported Employment
- Education Support Services
- Non-Medical Transportation

Tier 2 HCBS

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Family Support and Training

No Tier

- Short-term Crisis Respite
- Intensive Crisis Respite

Upcoming

- Self-Directed Services (pilot)

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HCBS Eligibility (streamlined from original process)

- Health Home conducts HARP HCBS Eligibility Assessment – IDs behavioral health HCBS eligibility tier
- Members goals for the tier of service IDed
- Specific BH HCBS services recommended
- HARP / HIV SNP can approve service determination prior to a plan of care being approved
- Full Community Mental Health Assessment within 90 days of Step 1
- Plan of Care Development
- Plan of Care to HARP / HIVSNP for approval

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ACCESSING SERVICES

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Managed Care Model Contract Revisions

- MMC Contract is being revised to reflect BH carve-in
  - Contains new service carve-ins
  - Network adequacy requirements
  - Beneficiary protections to support access to services
- Revised Contract not publicly available as of July 2016
  - Awaiting CMS approval, but in effect
  - Advocacy Tip: Try to request revised contract as part of evidence pack for BH related hearings.

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Contract Revisions: Access to BH Services

- Unlimited self-referrals to participating providers for mental health and substance use disorder assessments without prior authorization or PCP referral
  - Not applicable to ACT, inpatient psychiatric hospitalization, partial hospitalization and HCBS
- If BH dx, access to unlimited courses of smoking cessation without formulary restrictions
- PCP who works for OMH/OASAS clinic may be enrollee's PCP

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Contract Revisions: Access to BH Services

- No Prior Authorization for
  - Urgent /non-urgent ambulatory services at OMH and OASAS outpatient clinics, integrated clinics, and medically supervised outpatient withdrawal and stabilization programs
  - 72 hour supply of BH prescribed medication
  - 7 day supply of medication associated with management of opioid withdrawal / stabilization
  - Typical long-acting antipsychotics

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Continuity of Care

- No utilization review of BH services for first 90 days after carve-in
- 2 Year Continuity of Care to continue services for "Continuous Behavioral Health Episodes of Care" from BH provider had at carve-in (Utilization review may be used after 90 days)
- FFS rates for 24 months from carve-in for OMH licensed ambulatory services

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Utilization Management

- OMH, DOH & OASAS guidance on appropriateness of utilization management for specific services
  - https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/related_links/docs/bh_policy_guidance_10-1-15.pdf
  - Guidance will be incorporated by reference in contract

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Network Adequacy

- Offer contract to OMH or OASAS providers treating five or more active plan members
  - Contract must be for two years
  - FFS rate paid
- Specific network requirements for most service
- Specific appointment availability guidelines
- Time and distance standards same as for physical health

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Medical Necessity

Medical necessity is always the standard in Medicaid:

Care, services and supplies "necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law."

- N.Y. Soc. Serv. Law, § 365-a(2)

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Medical Necessity - HCBS

- Need to fit necessity of HCBS within the existing medical necessity definition.
  - Argue medical necessity for HCBS has to be person centered and look at the whole plan of care and how services "will help the enrollee's needs to support sustained recovery from a serious mental illness or substance use disorder." RFQ at 61.
  - Argue services are medically necessary when it will help an enrollee "prevent, manage and ameliorate chronic health conditions and recover from serious mental illness or substance use disorder." Implementation Guidance at 39
  - Use beneficial utilization management criteria in DOH/OMH/OASAS Guidance to support arguments.

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Hearable Issues

- Definitely Hearable (with aid-continuing)
  - MCO denials, discontinuances, reductions of any service, including BH and HCBS denials
  - Disagree with HCBS assessment or reassessment (Implementation Guidance at 8)
- Arguably Hearable*
  - HH or Care Manager failure to include or continue a service in a Plan of Care

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Carve-in and Service Start Timeline

October 1, 2015	NYC: Adult BH carve in to MMC / HARP / HIV SNP
January 1, 2016	NYC: HCBS services available through HARP / HIV SNP
July 1, 2016	ROS: Adult BH carve in to MMC / HARP / HIV SNP
October 1, 2016	ROS: HCBS services available through HARP
July 2017	NYC, LI, Westchester: Children's BH carve in to MMC
January 2018	ROS: Children's BH carve in to MMC

ROS = Rest of State

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For More Information

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Amy Lowenstein:
Alowenstein@EmpireJustice.org

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Power Point 2

Behavioral Health in Medicaid Managed Care

ADDICTION & MENTAL HEALTH INSURANCE PARITY

LEGAL ACTION CENTER

SEPT. 15, 2016
NYSBA PARTNERSHIP CONFERENCE

1

WHO IS YOUR PRESENTER?

Karla Lopez, Esq.
Staff Attorney
Legal Action Center

LEGAL ACTION CENTER

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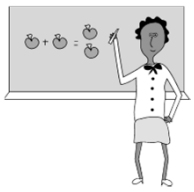
WHO IS THE LEGAL ACTION CENTER?

- Non-profit law & policy organization
- Anti-discrimination & privacy work
  - Substance Use Disorders
  - HIV/AIDS
  - Criminal Records
- Legal services, litigation, policy, technical assistance

LEGAL ACTION CENTER

3

WHAT WILL TODAY'S TRAINING COVER?



1. Overview of the federal parity law
2. Who must comply with the federal parity law?
3. What does the federal parity law require?
4. How can patients & providers enforce their rights under the law?
5. Other laws to know

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ADDITIONAL RESOURCES

- LAC Parity Guide: http://lac.org/health-insurance-for-addiction-mental-health-care-a-guide-to-the-federal-parity-law/
- LAC parity resources: http://lac.org/resources/substance-use-resources/parity-health-care-access-resources/
- ParityTrack: www.paritytrack.org
- SAMHSA's parity web page: http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- Coalition for Whole Health: www.coalitionforwholehealth.org

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1. OVERVIEW OF THE FEDERAL PARITY LAW

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT OF 2008

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FEDERAL PARITY LAW: OVERVIEW

- The Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA or **"federal parity law)** became federal law in October 2008, after 12 years of advocacy
- According to Congress, the **purpose** of the federal parity law is "to counter a history of discrimination and stigma against mental illness and substance-related disorders that has resulted in much less access to care."

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FEDERAL PARITY LAW: OVERVIEW

- The federal parity law requires most health insurance plans that cover mental health (MH) & substance use disorder (SUD) benefits to cover them **equally** (at "parity") with other medical & surgical benefits

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FEDERAL PARITY LAW: OVERVIEW

- This means that it should no longer be more difficult for a patient to have her addiction treatment covered by her health insurance than to have her diabetes treatment covered.

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FEDERAL PARITY LAW: OVERVIEW

Note on State Law:

- New York also has a **state** parity law
- New York passed laws in 2014 & 2016 to address opioid crisis—additional insurance protections for New Yorkers
- Today's training will focus on the **federal** parity law, but corresponding written materials provide more info on state laws

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2. WHO MUST COMPLY WITH FEDERAL PARITY LAW?

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FEDERAL PARITY LAW: WHO MUST COMPLY

First, a few definitions….

- **Grandfathered** plans are those that were in place on **March 23, 2010** and have not made certain changes since then
- **Non-grandfathered** plans are those that were created after **March 23, 2010**, or those created before March 23, 2010 that have made certain changes since then
- **Marketplace** refers to the health insurance exchanges & marketplaces created by the Affordable Care Act (ACA)—NY's is called NY State of Health

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FEDERAL PARITY LAW: WHO MUST COMPLY

Definitions, cont….

- **Self-Insured** plans: employer pays directly for employees' health care claims; employers usually hire third-party insurance company for administrative services such as enrollment and claims processing.
- **Fully-Insured** plans: employer purchases a health plan on the commercial market and pays premiums to an insurance company to cover the cost of its employees' health care claims.

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FEDERAL PARITY LAW: WHO MUST COMPLY?

- Most private and public health insurance plans **must comply** with the federal parity law, including:
  - Large group health plans
  - Medicaid Managed Care plans
  - Medicaid Alternative Benefit Plans (ABPs), including those provided to Medicaid expansion population
  - Children's Health Insurance Program (CHIP)
  - Individual plans

Cont…

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FEDERAL PARITY LAW: WHO MUST COMPLY?

- Plans that **must comply** cont'd:
  - Small group plans sold on NY State of Health marketplace
  - Non-grandfathered small group plans offered outside NY State of Health marketplace
  - Most state & local government employer plans
    - (Self-insured state & local govt. plans can opt out)
  - Most church-sponsored plans
    - (Church-sponsored plans can opt out)

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FEDERAL PARITY LAW: WHO MUST COMPLY?

- But, some health insurance plans **do not** have to comply with parity, including:
  - Medicare
  - Traditional (fee-for-service) Medicaid
  - Plans that have successfully applied for a cost-increase exemption
  - Grandfathered small group plans offered outside the NY State of Health marketplace
  - Retiree-only plans
  - TriCare (*but proposed regulations would bring in line with parity*)
  - Plans that are permitted to opt out (see previous slide)

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FEDERAL PARITY LAW: WHO MUST COMPLY?

Note on federal parity law & ACA:

- The **Affordable Care Act (ACA)** expanded the reach of the federal parity law by requiring additional types of health insurance plans to comply with parity
- Not every type of plan listed in the "who must comply" slide was covered by the 2008 parity law; some were added in 2010 by the ACA (and some added in 2009 by CHIPRA)

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FEDERAL PARITY LAW: WHO MUST COMPLY?

Note on federal parity law & ACA, cont….

- The federal parity law does <u>not</u> require health insurance plans to cover MH & SUD benefits; it only imposes requirements on plans that <u>do</u> choose to provide such benefits.
- <u>However</u>, the Affordable Care Act (ACA) includes MH & SUD benefits in its list of Essential Health Benefits, meaning certain types of plans—namely plans sold to individuals & small groups on the marketplace and Medicaid plans for the "expansion population" under the ACA—must cover those benefits <u>and</u> cover them at parity

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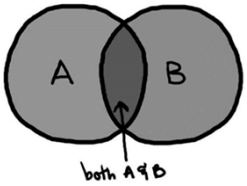
FEDERAL PARITY LAW: WHO MUST COMPLY?

- Therefore, some plans **must** provide MH & SUD benefits to comply with the ACA, **and** they must provide the MH & SUD benefits equally with medical & surgical benefits because of the federal parity law.



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SUMMARY: WHO MUST COMPLY?

If offer MH/SUD, must comply with parity	Must offer MH/SUD, *and* comply with parity	Not required to offer MH/SUD or comply with parity
• Large group plans • Medicaid Managed Care • CHIP • Grandfathered individual plans offered outside marketplace/ exchange • State & local govt. employers* • Church-sponsored* ** can opt out*	• Individual & small group plans sold on marketplace • Non-grandfathered small group & individual plans offered outside marketplace • Medicaid plans covering expansion population, including ABPs	• Medicare • Traditional (fee-for-service) Medicaid • Grandfathered small group plans offered outside marketplace • Plans w/cost increase exemption • Retiree-only plans • Tri-Care

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3. WHAT DOES THE FEDERAL PARITY LAW REQUIRE?

21

FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

- The federal parity law (MHPAEA) says:
  - the **financial requirements** and **treatment limitations** imposed by insurers on MH & SUD benefits
  - cannot be **more restrictive**
  - than the **predominant** financial requirements and treatment limitations
  - that apply to **substantially all** medical & surgical benefits.
- In essence: MH/SUD benefits, if provided, must be provided equally with other medical/surgical benefits

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

What does all that mean?

23

FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

- First, what are **financial requirements** and **treatment limitations**?

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

What are **financial requirements**?

- ❑ Deductibles
- ❑ Co-payments
- ❑ Co-insurance
- ❑ Out-of-pocket maximums

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

What are **treatment limitations**?

- There are 2 kinds of treatment limitations:
  1. Quantitative Treatment Limitations
  2. Non-Quantitative Treatment Limitations (NQTLs)

Cont....

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

What are **treatment limitations**?

- Quantitative treatment limitations are those expressed numerically, such as:
  - ❑ Limits on the number of **days** or **visits** covered
  - ❑ Limits on the **frequency** of treatment

Cont....

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

What are **treatment limitations**, cont…

- Non-Quantitative treatment limitations (NQTL) are not expressed numerically, but otherwise limit scope/duration—i.e., medical management tools:
  - ❑ Medical necessity criteria
  - ❑ Pre-authorization requirements
  - ❑ Prescription drug formulary design
  - ❑ Fail-first or step therapy policies

Cont....

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

What are **treatment limitations**, cont…

- Non-Quantitative treatment limitations (NQTL), cont…
  - ❑ Standards for provider admission to participate in-network
  - ❑ Determination of usual, customary, reasonable amounts
  - ❑ Exclusions based on failure to complete a course of treatment

**Note: this is not an exhaustive list*

29

CASE STUDY: QUESTION

- Jay visits a psychologist once per week. His health insurance plan requires a $50 co-payment each time he visits his psychologist.
- Is this co-payment either a financial requirement or treatment limitation that is covered by the federal parity law?

30

CASE STUDY: CORRECT ANSWER

- **Yes**, co-payments (like the $50 Jay must pay each time he sees his psychologist) are financial requirements, and therefore they must comply with the federal parity law.

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

- Now that we've discussed financial requirements & treatment limitations….
  - How do you know if they are **more restrictive** for MH/SUD benefits than for other medical/surgical benefits?
- *(Remember: The federal parity law (MHPAEA) says the financial requirements and treatment limitations imposed on MH & SUD benefits cannot be **more restrictive** than the predominant financial requirements and treatment limitations that apply to substantially all medical & surgical benefits.)*

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

- The federal parity law's regulations require
  - all of a plan's MH/SUD benefits
  - and all of its medical/surgical benefits
  - to be placed in one of either **6 classifications** (for private insurance) or **4 classifications** (for Medicaid & CHIP),
  - and provide a **formula** for comparing MH/SUD and medical/surgical benefits within each classification.

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Classifications

- 6 classifications (for private insurance):
  1. Inpatient, in-network
  2. Inpatient, out-of-network
  3. Outpatient, in-network
  4. Outpatient, out-of-network
  5. Emergency care
  6. Prescription drugs

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Classifications, cont'd

- 4 classifications (for Medicaid & CHIP):
  1. Inpatient
  2. Outpatient
  3. Emergency care
  4. Prescription drugs

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Classifications, cont'd

- MH/SUD benefits in a given classification—such as inpatient, in-network—will be compared with other medical/surgical benefits **in that same classification** to determine whether the financial requirements & treatment limitations on the MH/SUD benefits are **more restrictive**.
- In other words, **compare like with like**.

36

CASE STUDY: QUESTION

- Jay is wondering whether the $50 co-payment he is required to pay at his weekly visit to his psychologist complies with the parity law—that is, whether this financial requirement for an MH/SUD benefit is equal to similar medical/surgical benefits.
- Should Jay check to see whether the $50 co-payment for his psychologist visits is equal to:
  A. The co-payment he makes when he visits his primary care physician when he is sick, or
  B. The co-payment he makes for a visit to the emergency room?

37

CASE STUDY: CORRECT ANSWER

A. The co-payment he makes when he visits his primary care physician when sick

- Jay first needs to find out how his insurance plan classifies his psychologist visits, but they are most likely in the "outpatient" category.
- Therefore, Jay would need to compare his co-payment for the psychologist—an outpatient visit—to his co-payment for outpatient visits on the medical/surgical side, such as visits to a primary care physician when he's sick.
- By contrast, a visit to the emergency room would fall into the "emergency care" category, and therefore its co-payments should not be compared to co-payments in the "outpatient" category.

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CASE STUDY: CORRECT ANSWER, CONT.

Remember: Compare like with like!

MH/SUD	Medical/Surgical
Inpatient • Detoxification	**Inpatient** • Appendicitis
Outpatient • Psychologist visit	**Outpatient** • Primary care visit for flu
Emergency Care • ER for overdose	**Emergency Care** • ER for broken leg
Prescription Drugs • Suboxone	**Prescription Drugs** • Blood pressure medication

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Sub-classifications:

- Remember: all benefits go into 6 classifications (private insurance) or 4 classifications (Medicaid/CHIP)
- Within these 4 – 6 classifications, plans are permitted to make 2, *and only 2*, sub-classifications:
  1) In the outpatient classification, a plan may make sub-classifications separating office visits from all other outpatient services
  2) In the in-network classifications, a plan may create multiple tiers of in-network providers (e.g., preferred providers & participating providers)

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CASE STUDY: QUESTION

- Hailey's plan divides its outpatient classifications into two sub-classifications: office visits & all other outpatient items & services.
- Accordingly, her plan imposes a $20 co-payment for office visits & 20% co-insurance for outpatient surgery.
- These financial requirements are not applied more restrictively to MH/SUD benefits than to medical/surgical benefits.
- In dividing its outpatient classifications in this way, does Hailey's plan violate the federal parity law?

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CASE STUDY: CORRECT ANSWER

- No, these sub-classifications do not violate the federal parity law.
- The federal parity law permits plans to create a sub-classification in the outpatient classification for office visits vs. other outpatient services.

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Sub-classifications, cont'd:

- If a plan uses sub-classifications, compare MH/SUD benefits in a sub-classification to medical/surgical benefits in the same sub-classification
- For example, compare MH/SUD benefits in the outpatient/office visit sub-classification to medical/surgical benefits in the outpatient/office visit sub-classification, not to medical/surgical benefits in the outpatient/other services sub-classification

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

One more thing about classifications:

- If a health plan offers MH/SUD benefits in any classification, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided.

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CASE STUDY: QUESTION

- Gloria's health plan covers both outpatient and inpatient treatment for medical/surgical ailments. For example, it covers outpatient visits to her primary care doctor when she gets sick, and inpatient stays at the hospital when she has appendicitis.
- Her plan also covers outpatient MH/SUD treatment—for example, outpatient addiction counseling. However, her plan will not cover inpatient detoxification for her addiction.
- Does Gloria's plan meet the requirements of the federal parity law?

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CASE STUDY: CORRECT ANSWER

- **No**, it probably does not meet the requirements of the federal parity law (meaning it is probably illegal).
- Because Gloria's health plan offers MH/SUD benefits in **any** classification (in this case, it offers them in the outpatient classification), it must offer them in **every** classification in which it offers medical/surgical benefits (in this case, both outpatient and inpatient).

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

- Once all of the benefits have been put into one of the 6 or 4 classifications, how do you compare financial requirements & treatment limitations for MH/SUD vs. medical/surgical?
- *(Remember: The federal parity law (MHPAEA) says the financial requirements and treatment limitations imposed on MH & SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical & surgical benefits.)*

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

- For **financial requirements** and **quantitative treatment limitations**, cannot impose any on MH/SUD benefits that are separate from or more restrictive than the predominant ones applied to substantially all medical/surgical benefits in the same classification
- For **non-quantitative treatment limitations (NQTLs)**, cannot impose any on MH/SUD that are not comparable to those used for medical/surgical, and cannot apply them more stringently to MH/SUD than medical/surgical

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

What does all that mean?

49

FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

2/3

1/2

- What do you need to know about "**predominant**" and "**substantially all**"?
  - ❖ They are part of the **formula** for comparing MH/SUD benefits with medical/surgical benefits to determine whether they meet the requirements of the parity law.
  - ❖ "Substantially all" = at least **2/3**
  - ❖ "Predominant" = more than **1/2**

Cont...

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

- For more information about the formula & how to do the comparison, see your written materials.
- Or, if the detailed analysis is overwhelming, you simply can report possible violations of the parity law to the appropriate agencies—see upcoming Red Flags list.

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Red Flags:

- Having 1 deductible for MH/SUD services and 1 for medical/surgical services that accumulate separately
- Limits on the # of days or visits for MH/SUD treatment, when there aren't similar limits for medical/surgical
- Higher co-payments & co-insurance for MH/SUD than for medical/surgical (e.g., charging a "specialist" rate for MH/SUD outpatient visits, when a "specialist" rate isn't charged for most medical/surgical outpatient visits)

Cont....

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Red Flags, cont'd

- Requiring patient to "fail first" at MH/SUD outpatient treatment before approving residential or inpatient treatment (and not having similar policies for med/surgical)
- Requiring MH/SUD patients to get prior authorization at earlier stages of treatment or more frequently during treatment than medical/surgical patients

Cont....

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FEDERAL PARITY LAW: WHAT DOES IT REQUIRE?

Red Flags, cont'd

- Excluding intermediate levels of MH/SUD care, like residential treatment, from coverage, if the plan covers intermediate care (like skilled nursing) for medical/surgical
- Requiring MH/SUD patients to be treated in-state, but allowing medical/surgical patients to be treated out-of-state
- Putting yearly or lifetime limit on length of time patient can receive methadone, buprenorphine, or naltrexone

54

CASE STUDY: QUESTION

- Claire's physician has recommended inpatient treatment for her addiction. Claire's insurance plan requires pre-authorization for inpatient addiction treatment.
- When Claire had inpatient treatment for salmonella, no pre-authorization was required.
- Does Claire's plan comply with the federal parity law?

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CASE STUDY: CORRECT ANSWER

- The plan **may not** comply with parity.
- Pre-authorization requirements are a Non-Quantitative Treatment Limitation ("NQTL").
- Remember, plans cannot impose any NQTLs on MH/SUD that are not comparable to those used for medical/surgical.
- Here, it appears the MH/SUD NQTL (pre-authorization) is not comparable to the medical/surgical NQTL, in the inpatient classification, because pre-authorization is required for Claire's inpatient addiction treatment but not for her inpatient salmonella treatment.

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CASE STUDY: QUESTION

- Phil enters the hospital for an inpatient detoxification from opioids that will last 7 days.
- His health plan requires pre-authorization for inpatient addiction treatment *and also* for inpatient medical/surgical treatment.
- When Phil's physician applies for pre-authorization for his 7-day inpatient detox, the plan approves only one day at a time, requiring his physician to re-apply each day in order to complete his treatment.
- When Phil must spend a week in the hospital recovering from a surgical procedure, his insurance plan pre-authorizes the whole 7 days.
- Does Phil's plan comply with the federal parity law?

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CASE STUDY: CORRECT ANSWER

- **No**, the plan probably does not comply with parity law.
- Remember, plans cannot apply any NQTLs (like pre-authorization requirements) more stringently to MH/SUD than medical/surgical.
- Here, plan is applying the MH/SUD NQTL (pre-authorization requirements) more stringently than the medical/surgical NQTL, because it will approve only one day of inpatient treatment at a time for Phil's opioid detox, but will approve a full 7 days at once for his surgical recovery.

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A NOTE ON THE CASE STUDIES

- Remember that there is a **formula** to determine whether health insurance plans are complying with the federal parity law.
- Generally, health plans themselves & those who enforce the federal parity law (mostly government regulators) are the ones who will apply the formula to decide for sure whether a plan has violated the law.
- Our case studies don't go into that level of detail, but are more to give you a general idea of things that **probably** violate the law so that you can recognize them and do additional analysis or bring them to the attention of regulators.

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4. HOW TO ENFORCE RIGHTS UNDER FEDERAL PARITY LAW

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HOW TO ENFORCE PARITY RIGHTS

How to Enforce Rights under Federal Parity Law:

1. Transparency Requirements: request info from health plan
2. Internal appeal(s) with health plan
3. External appeal(s) with IRO
4. Medicaid only: Fair Hearing
5. Complain to government agencies
6. Lawsuit

NOTE: Not required to file appeals before complaining to gov't

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HOW TO ENFORCE PARITY RIGHTS

1. Transparency Requirements:

- Most plans covered by federal parity must provide the following info to patients & providers upon request:
  - ❑ Criteria used to make medical necessity decisions—both MH/SUD and medical/surgical
  - ❑ Written explanation of how non-quantitative treatment limitations (e.g., medical necessity criteria) are applied to their medical/surgical & MH/SUD benefits;
  - ❑ Reason for denials of payment or reimbursement;
  - ❑ Any additional evidence used to make benefit determinations during appeals.

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HOW TO ENFORCE PARITY RIGHTS

2-4. Internal & External Appeals, Fair Hearing

- File internal appeal(s) with health plan
- If plan upholds its denial of services, file external appeal with independent review organization (IRO)
- Make sure to mention federal parity law in any internal & external appeals to preserve the issue going forward
- Note: most plans have the right to expedited appeals, and NY has additional expedited appeal rights for people seeking SUD treatment
- Medicaid: Right to fair hearing

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies

- If you think a health plan is violating the federal parity law, you can **complain to the government agencies** that are tasked with enforcing the law, or you can complain to the State **Attorney General**.

Cont.....

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

New York State Attorney General:

- NYS AG is proactively enforcing the federal parity law
- If you think a NYS health plan is violating parity, you can call the AG's Health Care Bureau hotline:

1-800-428-9071

- Or use new online complaint form: https://www.ag.ny.gov/health-care-complaint-form?wssl=1

Cont…

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

New York State Attorney General, cont…

- AG has settled 5 cases against NYS health plans for parity violations: Cigna, MVP Health Care, Emblem Health, ValueOptions/ BeaconHealthOptions, & Excellus
- For information about what the AG said violated the parity law, as well as copies of the AG's settlement agreements, visit:

http://lac.org/resources/substance-use-resources/parity-health-care-access-resources/new-york-attorney-general-parity-enforcement/

Cont…..

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

New York State Attorney General, cont…

- The AG can also enforce other federal laws (like the ACA) and state laws (like the state parity law).

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

Other Govt. Enforcement Options:

- The federal parity law itself gives enforcement authority to a variety of state and federal agencies
- Different agencies enforce federal parity law for different types of health plans
- Remember, it is advisable to appeal directly to the insurance plan before going to a government agency

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

State Agencies

- Unless plan is *self-insured*, complain to state agencies first

Dept. of Fin. Svcs.	Dept. of Health
• Online complaint form: http://www.dfs.ny.gov/consumer/fileacomplaint.htm • Consumer Assistance Unit: (800) 342-3736	• Email: managedcarecomplaint@health.ny.gov • Phone: (800)206-8125

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

State Agencies

Dept. of Fin. Svcs.	Dept. of Health
Plan Types: • Fully-insured large group • Small group bought on marketplace • Non-grandfathered small group not bought on marketplace • Individual • Fully-insured state or local govt. employer	Plan Types: • Medicaid Managed Care • CHIP

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

Federal Agencies

- If state agencies are not "substantially enforcing" the federal parity law, or if a plan is self-insured, complain to federal agencies

Dept. of Labor	Dept. of Health & Human Svcs.
• Email: phig@cms.hhs.gov • Phone: (877) 267-2323	• Online: www.askebsa.dol.gov • Phone: (866) 444-3272

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HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

Federal Agencies

Dept. of Labor	Dept. of Health & Human Svcs.
Plans: • Self-insured large group plans (both grandfathered & non-grandfathered) • Self-insured state or local govt. plans	Plans: • Fully-insured large group • Small group bought on marketplace • Non-grandfathered small group not bought on marketplace • Individual • Fully-insured state or local govt. employer • Medicaid Managed Care • CHIP

HOW TO ENFORCE PARITY RIGHTS

3. Complain to Government Agencies, cont…

A few tips for complaining to govt. agencies:

- Mention the federal parity law specifically in your complaint—otherwise the agency may not look for parity violations
- Ask the government agency to provide you with its findings/conclusions in writing

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HOW TO ENFORCE PARITY RIGHTS

4. Lawsuit

- Depending on what type of health plan she has, a patient or provider may be able to enforce her rights under the federal parity law by filing a lawsuit
- Developing area of law—most litigation brought under ERISA
- *See, e.g., New York State Psychiatric Association v. UnitedHealth Group*, 798 F. 3d 125 (2d Cir. 2015).

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5. OTHER LAWS TO KNOW (NY)

75

OTHER LAWS TO KNOW

Court-Ordered Treatment—Insurance Coverage:

- NYS law requires Medicaid Managed Care plans in the state to cover court-ordered treatment (if the plan would otherwise cover that type of treatment)
- Example: Court orders defendant charged with sale of controlled substances into outpatient addiction treatment. If the person's Medicaid plan provides coverage for outpatient addiction treatment generally, it would be required to cover that type of treatment when ordered by a court.
- This law is found at New York Social Services Law section 364-j(4)(r)

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OTHER LAWS TO KNOW

- In June 2014, Gov. Cuomo signed a **package of bills into law to combat NY's opioid epidemic**. The new laws require:
  - All insurance policies that are regulated by the NYS Dept. of Financial Services and that provide hospital, major medical, or other similar comprehensive coverage must provide inpatient and outpatient services for the diagnosis & treatment of SUD, including detoxification & rehabilitation services.
  - Financial requirements & treatment limitations of such coverage cannot be more restrictive than medical/surgical, and the coverage must comply with the federal parity law.

Cont.....

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OTHER LAWS TO KNOW

2014 NY Laws to Combat Opioid Epidemic, cont…

- When NY insurers undertake utilization review for SUD treatment, they must employ "recognized evidence-based & peer reviewed clinical review criteria."
- NY insurers must complete utilization review within 24 hours of receiving a request for *inpatient* SUD treatment, as long as the request is made 24 hours prior to discharge from inpatient; cannot deny coverage while UR is pending on basis of medical necessity or lack of prior authorization.

Cont.....

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OTHER LAWS TO KNOW

2014 NY Laws to Combat Opioid Epidemic, cont…

- NY insurers must issue a decision within 24 hours of receiving an appeal of a denial of *inpatient* SUD treatment; if appeal is filed within 24 hours of the denial, insurer cannot deny treatment on the basis of medical necessity or lack of prior authorization while the appeal is pending.

Cont…..

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OTHER LAWS TO KNOW

2016 NY Laws to Combat Opioid Epidemic, cont…

- In June 2016 Gov. Cuomo signed another **package of bills into law to combat NY's opioid epidemic**.
- Visit www.lac.org for a summary of the 2016 laws

Cont…..

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THANK YOU!
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KEEP UP WITH THE LEGAL ACTION CENTER BY FOLLOWING US ON FACEBOOK, TWITTER, & LINKEDIN!
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Accessing Behavioral Health Services: Behavioral Health in Medicaid Managed Care & Using Parity Laws

Biographies

Panel Biographies

Karla Lopez

Karla Lopez is a Staff Attorney at the Legal Action Center, a non-profit law and policy organization that fights discrimination against people with substance use disorders, HIV/AIDS, and criminal records. At the Legal Action Center, Karla represents clients facing such discrimination, as well as clients whose HIV confidentiality has been breached. Karla also counsels and trains health and social services providers, as well as state and federal governments, on their obligations under anti-discrimination and privacy laws. Karla was the primary drafter of the Legal Action Center's forthcoming guide to the Mental Health Parity and Addiction Equity Act of 2008 (the federal parity law). Karla participated in writing and editing the 2012 edition of LAC's seminal book on the law governing the privacy of alcohol and drug treatment information, "Confidentiality and Communication: A Guide to the Federal Alcohol and Drug Confidentiality Law and HIPAA." Karla has also conducted numerous trainings about the federal parity law, laws governing the confidentiality of alcohol and drug treatment records, and employment rights for people with substance use disorders, HIV/AIDS, and viral hepatitis. Prior to joining the Legal Action Center, Karla worked on criminal justice reform at the Open Society Institute and Policy Center. Karla received her B.A. from Bard College and her J.D. Georgetown University Law Center, where she was a Public Interest Law Scholar.

Amy Lowenstein

Amy Lowenstein is a senior attorney with the Health Law Unit in the Albany office of the Empire Justice Center, a statewide, multi-issue, multi-strategy non-profit law firm focused on changing the "systems" within which poor and low income families live. Amy works to improve and strengthen health coverage and services for low-income populations in New York State. She represents the needs of healthcare consumers in a variety of settings, including within the state legislature and before state administrative agencies; analyzes legislative and administrative proposals impacting health access and coverage; and provides training and support to community-based organizations throughout the state through in-person trainings, webinars and written health policy updates. Amy's policy work includes collaborating with statewide coalitions as well as working with regulatory agencies to ensure that the changes to our health care system brought about by Medicaid Redesign and the Affordable Care Act meet the needs New York's most vulnerable populations. Prior to joining Empire Justice Center, Amy litigated disability rights and health law cases at Disability Rights New York and New York Legal Assistance Group. Amy received her J.D. from Columbia Law School and her B.A. in history from Wesleyan University.

Transitioning Adult Behavioral Health Services Into Medicaid Managed Care: Mental Health Contractual Provisions as of September 10, 2015

Expansion of the Medicaid Managed Care Benefit Package

Effective October 1, 2015 in New York City, and July 1, 2016 in the rest of the state, the following mental health programs and services will become covered benefits for ALL Medicaid Managed Care enrollees age 21 and over. Prior to the expansion of the benefit package, the mental health services covered by Medicaid Managed Care were inpatient psychiatric services in Article 28 facilities and Part 599 clinics services for non-SSI recipients.

Covered services will now include:

- Inpatient psychiatric services in Article 28 facilities
- Part 599 clinics services
- Behavioral health services in Part 598 integrated clinics
- Personalized Recovery Oriented Services (PROS) programs operated under Part 512
- Continuing Day Treatment (CDT) programs operated under Part 587
- Intensive Psychiatric Rehabilitation Treatment (IPRT) programs operated under Part 587
- Assertive Community Treatment (ACT) programs operated under Part 508
- Partial Hospitalization (PH) programs operated under Part 587
- Inpatient Psychiatric Hospitalization Services operated under Parts 580 or 582
- Comprehensive Psychiatric Emergency Programs (CPEPs) operated under Part 590
- Crisis Intervention
- Behavioral Health Home and Community Based Services (BHHCBS): available to eligible Health and Recovery Plan (HARP) and HARP-eligible HIV Special Needs Plan (SNP) enrollees only

With the upcoming transition, New York State (NYS) has provided Medicaid Managed Care plans with specific legal requirements and accompanying guidance regarding the process of entering into agreements with providers of these services.

Contractual Provisions

- New York State (NYS) is incorporating several key provisions into the Medicaid Managed Care Model contract that address:
    - Ensuring Medicaid Managed Care plans establish adequate behavioral health provider networks;
    - Promoting financial stability through payment and claiming requirements; and
    - Supporting access to and removing barriers to mental health treatment and recovery services.

- The Medicaid Managed Care Model Contract is being amended to reflect the expansion of covered benefits and to include the additional behavioral health services. The Medicaid provisions of provider agreements with the Medicaid Managed Care plans may need to be written or amended to reflect these requirements.
- The Medicaid Managed Care Model Contract provisions are applicable to only Medicaid Managed Care, HARP, and HIV SNP lines of business. Note that the proposed contract amendment is subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Because a number of clinics treat individuals with co-occurring disorders, provisions related to Substance Use Disorder medication access are highlighted in Attachment A as well.
- OMH providers are encouraged to review current and proposed amendments to provider agreements for consistency with the proposed Medicaid Managed Care Model Contract provisions outlined in Attachment A.
- Providers are **strongly** encouraged to finalize contracting with plans to ensure inclusion in Medicaid Managed Care provider networks prior to the effective date of the behavioral health benefit expansion.

ATTACHMENT A
Contract Requirements and Statute (where noted)

Topic / Policy	Section	BENEFIT PACKAGE REQUIREMENTS
BH Self - referrals	10.15 (a)(i)	Enrollees may obtain unlimited self-referrals for mental health and Substance Use Disorder assessments from participating providers without requiring preauthorization or referral from the enrollee's Primary Care Provider. This provision does not apply to ACT, inpatient psychiatric hospitalization, partial hospitalization and BH Home and Community Based Services.
Utilization Management (UM) and Level of Care Determinations	10.21 (a)	Service Authorization Determinations for mental health services must be made in accordance with utilization management criteria and level of care guidelines issued and/or approved by the Office of Mental Health.
Alternate Level of Care	10.21(c)	If the plan determines that an alternate level of care is appropriate, but has not identified an appropriate provider of such care (either in network or out of network), the plan must continue to approve coverage of and continue to reimburse for services provided by the current provider.
Ambulatory Patient Groups (APG)/Fee for Service (FFS) Rate Mandate	10.21 (d)	Government rates for 24 months from effective date of BH inclusion. For mental health, this **only** applies to OMH licensed ambulatory mental health services. NOTE: For clinics, this is also required per Section 13 of Part C of chapter 60 of the laws of 2014 amending Section 48-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws.
Continuity of Care Requirements	10.21 (e)	2 year continuity of care language affirms plans must permit enrollees to continue receiving services from their current provider(s) for "Continuous Behavioral Health Episodes of Care" (as defined in the Model Contract) for up to 24 months from the date of the Behavioral Health benefit inclusion in either NYC or the rest of state, respectively. Notwithstanding, plans may use OMH-approved UR criteria to review duration and intensity of such episodes of care.
	10.21 (f)	90 day transition language prohibits plans from applying utilization review criteria for a period of 90 days from the effective date of the Behavioral Health benefit inclusion in either NYC or the rest of state, respectively. Accordingly, plans must accept existing plans of care.
BH Pharmacy	10.32	Except where otherwise prohibited by law, pharmacy services

ATTACHMENT A
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Topic / Policy	Section	BENEFIT PACKAGE REQUIREMENTS
Access		include immediate access / no prior authorization language for BH prescribed drugs 72 hour supply generally; and 7 day supply for prescribed drug or medication associated with the management of opioid withdrawal and / or stabilization.
OMH Certification Meets Credential Requirements	21.4 (b)	Directs the plan to credential the OMH licensed and OASAS certified program and that the license / certification shall suffice for plan contracting requirements and that the plan may not separately credential individual staff members. The contract requires that the plans shall still collect, accept, and review Medicaid program integrity related information as required by the State Contract and Medicaid regulations.
BH HCBS Designation Meets Plan Credential Requirements.	21.4 (d)	HARP and HIV SNP only provision that directs the plan to accept the NYS BH HCBS designation to satisfy the plans BH HCBS credentialing; plan may not separately credential a provider's staff members; and affirms that contractor shall still collect and accept program integrity related information as required by the State Contract and Medicaid regulations.
Primary Care in OMH Programs /PCPs	21.14 (e)	Adding PCPs employed by OMH and OASAS clinic programs as eligible primary care providers. The enrollee must choose or be assigned a specific provider or provider team within the clinic to serve as his/her PCP. All PCPs employed by clinics must meet the same plan credentialing standards as any other PCP in the plan's network.
5 or more for members	21.19 (a)(ii)	Prior to the date of BH inclusion in the Medicaid benefit, plans must offer to contract with any OMH or OASAS providers with five or more active plan members. This list is provided to the plans by NYS and the requirement is for 24 months from the date of the Behavioral Health benefit inclusion in either NYC or the rest of state, respectively.

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Topic / Policy	Section	BENEFIT PACKAGE REQUIREMENTS
Part 599 Clinics (other than State-operated clinics) and Part 598 integrated clinics	21.19 (b) (i) (A)	At a minimum, the plan's network must include: • 50% of all clinic sites or a minimum two clinic sites per county, whichever is greater; • To ensure enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the plan's service area. • Must include clinic providers that offer urgent and non-urgent same day, evening and weekend services; • Where an authorized integrated outpatient service provider is in the plan's network, the plan shall contract for the full range of integrated outpatient services provided by such provider. Additional providers may be necessary to demonstrate network adequacy.
PROS programs operated under Part 512, Continuing Day Treatment programs operated under Part 587, and IPRT programs operated under Part 587	21.19 (b)(i) (B)	At a minimum, the plan's network must include: • For urban counties: network must include 50% of all such providers or two providers per county, whichever is greater. • For rural counties: network must include 50% of all such providers or two providers per region, whichever is greater. Additional providers may be necessary to demonstrate network adequacy.
ACT programs operated under Part 508	21.19 (b) (i)(C)	At a minimum, the plan's network must include: • For urban counties: network must include two providers per county. • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.
Partial Hospitalization programs operated under Part 587	21.19 (b)(i)(D)	At a minimum, the plan's network must include: • For urban counties: network must include two providers per county. • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.

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Topic / Policy	Section	BENEFIT PACKAGE REQUIREMENTS
Inpatient Psychiatric Hospitalization Services operated under Parts 580 or 582	21.19 (b)(i)(E)	At a minimum, the plan's network must include: • For urban counties: network must include two providers per county • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.
Comprehensive Psychiatric Emergency Programs operated under Part 590	21.19 (b)(i)(F)	At a minimum, the Plan's network must include: • For urban counties: network must include two providers per county • For rural counties: network must include two providers per region. Additional providers may be necessary to demonstrate network adequacy.
Crisis Intervention	21.19 (d)	The Contractor's network must include an adequate number of Crisis Intervention service providers in accordance with the State issued Guidance
State-operated ambulatory mental health services and State-operated providers of Behavioral Health Home and Community Based Services	21.19 (e)	The Contractor's network must include all State-operated providers in each region that contains a county within the plan's service area
APG reimbursement	21.19 (f)	This provision reaffirms the APG reimbursement requirement for outpatient mental health and Substance Use Disorder services in various settings citing the relevant statutory authority.
All products prohibition language	NEW 22.3 (b)	The contractor is prohibited from conditioning the participation of a BH provider upon agreement to participate in a Contractor's non-Medicaid line(s) of business.
Alternative Payments Permission	22.5 (k)	Requirement that for BH providers, proposed alternative payment arrangements must be submitted to and approved by OMH / OASAS, as applicable.
Two year Contract	22.5 (l)	For OMH or OASAS providers with five or more active plan members, with whom plans are required to contract, this provision requires the Contractor to include language in the

ATTACHMENT A Contract Requirements and Statute (where noted)		
Topic / Policy	**Section**	**BENEFIT PACKAGE REQUIREMENTS**
		provider contract that the contract is minimum two year term and that the contractor will pay the applicable Medicaid fee-for-service rate.
No prior authorization	No prior authorization Appendix F	The Contractor shall not require prior authorization for either urgent or non-urgent ambulatory services delivered by: OASAS certified Part 822 outpatient clinics (including intensive outpatient services), outpatient rehabilitation and opioid treatment programs, OASAS certified Part 816 medically supervised outpatient withdrawal and stabilization programs, OMH Part 599 licensed outpatient clinics (including community mental health services), OASAS Part 825 integrated clinics, OMH Part 598 integrated clinics and Title 10 Part 404 Diagnostic and Treatment Centers.[1]
Access to drugs used for SUD treatment on both medical benefit and formulary	SUD medication Appendix K, #10	Drugs used for the treatment of Substance Use Disorders are covered by the contractor: consistent w / FDA labeling and compendia; include medications for SUD opioid dependency in the formulary; at least one formulation of buprenorphine and buprenorphine / naloxone; Vivitrol covered as a medical and a pharmacy benefit. Language affirms that Naloxone is available in atomizers in addition to: vials; prefilled syringes and auto injectors
Access to long-acting injectable on both medical benefit and formulary	MH medication Appendix K, #10	Long-acting injectable medications must be covered by the Contractor as a medical and pharmacy benefit. The Contractor's clinical criteria for coverage for long acting antipsychotic injectable medication quantity/dose/age limits shall be consistent with FDA approved labeling and Official Compendia.
Smoking Cessation	Appendix K, #11	Unlimited courses of smoking cessation products are available for enrollees with one or more Substance Use Disorder(s) or mental illness(s). The contractor may not impose any limitations or formulary coverage restrictions on this benefit.
Long-Acting Injectable	No prior authorization Appendix F	The Contractor shall not require prior authorization of typical long-acting antipsychotics (e.g., haloperidol decanoate and fluphenazine decanoate).

[1] OMH has issued guidance to MMCPs which further outlines requirements related to prior authorization. Please note this guidance includes a requirement prohibiting prior authorization for pre-admission screening in OMH Part 512 PROS programs

Behavioral Health in Medicaid Managed Care
NYSBA Partnership Conference
September 15, 2016

I. Background and Overview

A. In 2011, as part of Medicaid Redesign, New York began expanding the integration of certain populations and services from fee-for-service (FFS) Medicaid to a managed care model.

B. The NYS Department of Health (DOH) convened the Medicaid Redesign Team Behavioral Health Reform Workgroup.
   1. The Workgroup was charged with making recommendation for the integration of behavioral health and physical health services.[1]
   2. The Workgroup's recommendations ultimately led to New York seeking an amendment to its 1115 Medicaid Waiver to carve all behavioral health services into managed care and to create specialty managed care plans – Health and Recovery Plans (HARPs) – to better coordinate services for higher need individuals and through which behavioral health services not traditionally available under Medicaid could be obtained.[2]

C. The behavioral health carve in moves Medicaid funded programs operated and licensed by the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) from fee-for-service Medicaid to managed care.

D. Accessing Adult Behavioral health service delivery before carve-in: FFS vs. MMC
   1. Behavioral health services that were only available through FFS Medicaid even for people in MMC:
      a. Outpatient Clinic and Opioid Treatment Program (OTP) services (OASAS)
         i. Chemical Dependency Outpatient Clinic (CD-OPs)
            Office certified program providing outpatient services to individuals with substance use disorders and their family or significant others; CD-OPs also may provide outpatient rehabilitation services and/or intensive outpatient services.[3]

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[1] New York State Department of Health. "Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations" at 2 (October 15, 2011) (hereinafter "Behavioral Health Work Group Recommendations"), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf (last visited Jul. 27, 2016).

[2] Centers for Medicare & Medicaid Services. Section 1115 of the Social Security Act Medicaid Demonstration New York Partnership Plan Waiver Number 11-W-00114/2 at 4 (hereinafter "Partnership Plan"), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/Partnership-Plan/ny-partnership-plan-tech-corr-09182015.pdf (last visited Jul. 27, 2016). This document reflects the agreed upon terms of the Partnership Plan as of September 18, 2015 and includes special terms and conditions for the various provisions of the waiver.

[3] 14 N.Y.C.R.R. § 822.5(j).

ii. OTP Office
Certified sites where methadone or other approved medications are administered to treat opioid dependency.[4]

b. Continuing Day Treatment (CDT) (OMH)
A program for adults with serious mental illness aimed at providing them with skills and supports to remain in the community and work toward a more independent level of functioning.[5]

c. Partial Hospitalization (OMH)
A medically supervised program that provides mental health treatment to stabilize or ameliorate acute symptoms in a person who would otherwise need hospitalization.[6]

d. Personalized Recovery Oriented Services (PROS) (OMH)
A comprehensive recovery oriented program for individuals with serious mental illness. "The goal of the program is to integrate treatment, support, and rehabilitation in a manner that facilitates the individual's recovery."[7]

e. Assertive Community Treatment (ACT) (OMH)
"Comprehensive and integrated set of psychiatric, psychosocial rehabilitation, case management and support services provided by a mobile multi-disciplinary mental health treatment program mainly in the client's residence or other community locations."[8]

f. Intensive Psychiatric Rehabilitation Treatment (IPRT) (OMH)
"[T]ime limited rehabilitative program for adults and/or adolescents which focuses on building skills and developing community supports to assist individuals to attain a specific residential, learning, working or social goal(s).[9]

g. Rehabilitation services for residents of community residences (OASAS) - Rehabilitative services designed to change substance use disorder behavior for individuals who reside in OASAS residential settings.[10]

2. Behavioral health services that were available through MMC for <u>all</u> MMC enrollees:

a. Medically supervised outpatient withdrawal (OASAS)
"[S]ervices to clients who suffer moderate alcohol or substance withdrawal, do not meet the admission criteria for medically managed or inpatient medically supervised detoxification services, and who have

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[4] 14 N.Y.C.R.R. § 822.5(w).
[5] New York State Office of Mental Health. Licensed Program Type Definitions (hereinafter "OMH Program Type Definitions"), *available at* https://www.omh.ny.gov/omhweb/licensing/definitions.htm (last visited Jul 27, 2016); 14 N.Y.C.R.R. § 587.10.
[6] OMH Program Type Definitions; 14 N.Y.C.R.R. § 587.12.
[7] New York State Office of Mental Health. Personalized Recovery Oriented Services (PROS), *available at* https://www.omh.ny.gov/omhweb/pros/ (last visited Jul. 27, 2016); 18 N.Y.C.R.R. Part 512.
[8] OMH Program Type Definitions; 14 N.Y.C.R.R. § 508.4.
[9] OMH Program Type Definitions; 14 N.Y.C.R.R. § 587.13.
[10] New York State Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services. New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual at 26 (Sep. 1, 2015), *available at* https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf (last visited Jul. 27, 2016).

emotional support and a home environment able to provide an atmosphere conducive to outpatient withdrawal leading to recovery."[11]

b. Health Home coordination
The coordination of an individual's care through a "dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status so that the member's medical, behavioral health and social service needs are addressed in a comprehensive manner.[12]

c. Inpatient hospital detoxification (OASAS)
Hospital based management of acute intoxication and withdrawal symptoms.[13]

d. Medically supervised inpatient detoxification (OASAS)
"[B]io-psycho-social assessment, medical supervision of intoxication and withdrawal conditions; pharmacological services; individual and group counseling; level of care determination; and referral to other appropriate services.[14]

3. Behavioral health services that were only available FFS for people on Medicaid due to SSI or disability, but available through MMC for all others:
   a. Outpatient clinic services (OMH)
   Clinic based provision of "an array of treatment services for assessment and/or symptom reduction or management, including individual and group therapies and medication management."[15]
   b. Comprehensive Psychiatric Emergency Program (CPEP) (OMH)
   "[H]ospital based program which provides access to crisis outreach, intervention, and residential services; and/or provides beds for the extended observation (up to 72 hours) to adults who need emergency mental health services."[16]
   c. Inpatient treatment services (OASAS)
   Structured 24-hour intensive services for people with substance use disorder that is provided in a hospital or free-standing facility.[17]
   d. Inpatient psychiatric services (OMH)
   "24 hours per day hospital based program which includes psychiatric, medical, nursing, and social services which are required for the

[11] New York State Office of Alcoholism and Substance Abuse Services. Substance Use Disorder Service Descriptions (hereinafter "OASAS Service Descriptions"), *available at* https://www.oasas.ny.gov/hps/state/CD_descriptions.cfm (last visited Jul. 27, 2016); 14 N.Y.C.R.R. § 816.8.
[12] New York State Department of Health. Health Homes Provider Manual: Billing Policy and Guidance at 9 (Jan. 9, 2014), *available at* https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf (last visited Jul. 27, 2016).
[13] 14 N.Y.C.R.R. § 816.6.
[14] OASAS Service Descriptions; 14 N.Y.C.R.R. § 816.7.
[15] OMH Program Type Definitions; 14 N.Y.C.R.R. Part 599.
[16] OMH Program Type Definitions; 14 N.Y.C.R.R. Part 590.
[17] OASAS Service Descriptions; 14 N.Y.C.R.R. Part 818.

assessment and or treatment of a person with a primary diagnosis of mental illness…. "[18]

II. The Behavioral Health Carve-In

A. People enrolled in Medicaid managed care receive all Medicaid behavioral health services through managed care except rehabilitation supports associated with OMH Community Residences.[19] Rehabilitation supports associated with OMH Community Residence continue to be available only through FFS Medicaid.

B. The carve-in to managed care of behavioral health services is currently only for adults 21 and over who are eligible to receive services through one of three types of Medicaid Managed Care Organizations (MCOs):
   1. Mainstream Medicaid managed care (MMC)
   2. HIV Special Needs Plans (HIV SNPS) (only available in NYC)
   3. Health and Recovery Plans (HARPs)

C. People who are excluded or exempt from MMC, HIV SNPs and HARP continue to receive behavioral health services through FFS Medicaid. This excluded population includes:
   1. People dually eligible for Medicaid and Medicare
   2. People with a Medicaid spenddown
   3. People who have Medicaid and third party health insurance

D. DOH has requested a waiver to carve children's behavioral health services in to managed care, but that request has not been approved yet.[20]

E. All MMCs, HARPs and HIV SNPs must
   1. Provide all state plan BH services[21]
   2. Coordinate physical and behavioral health[22]
   3. Use behavioral health specific performance metrics[23]
   4. Work within an annual behavioral health expenditure target (HIV SNPs and MMC) or assure that 89% of premiums are expended on physical and behavioral health care. Savings and or expenditures will be reinvested in behavioral health services.[24]

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[18] OMH Program Type Definitions.
[19] Partnership Plan at 90.
[20] *Id.* at 20, 90
[21] NYS Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services. New York Request for Qualification for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans at 11 (Mar. 21, 2014) (hereinafter, "RFQ"), *available at* https://www.omh.ny.gov/omhweb/bho/final-rfq.pdf (last visited Jul. 27, 2016).
[22] NYS Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services. Rest of State Adult Behavioral Health Request for Qualification (RFQ): Applicant's Conference-Updated (powerpoint) at 10 (Aug 28, 2015), *available at* https://www.omh.ny.gov/omhweb/bho/docs/ros_applicant_conference.pptx (last visited Jul. 27, 2016).
[23] New York State Section 1115 Behavioral Health Partnership Plan Waiver Amendment application at 19 (Dec. 30, 2013) (hereinafter "Waiver Amendment application", *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/1115_waiver_behavioral_health_amendment.pdf (last visited Jul. 27, 2016).
[24] NYS Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services. Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation at 48-49 (October 2015) (hereinafter "Implementation Guidance"), *available at*

F. Timeline for carve-in of behavioral health services into managed care[25]
   1. October 1, 2015 - NYC: Adult BH carve in to MMC / HARP / HIV SNP
   2. January 1, 2016 - NYC: HCBS services available through HARP / HIV SNP
   3. July 1, 2016 – Rest of State (ROS): Adult BH carve in to MMC / HARP / HIV SNP
   4. October 1, 2016 -ROS: HCBS services available through HARP
   5. July 2017 – NYC, Long Island & Westchester: Children's BH carve in to MMC[26]
   6. January 2018 - ROS: Children's BH carve in to MMC

G. MCOs must go through a qualification process prior to being approved to manage the BH and HCBS services.[27]
   1. Separate qualification process for serving adult population and children.[28]
   2. Plan can qualify to manage behavioral health benefit on its own or by contracting with a behavioral health organization.[29]

III. Health and Recovery Plans (HARPs)

A. HARPs are specially qualified to serve people with serious behavioral health conditions.[30]

B. Eligibility is based on behavioral health service utilization or functional impairment.
   1. DOH will identify HARP-eligible enrollees on a quarterly basis who meet both Targeting and Risk Factor Criteria.[31]
      a. Targeting Criteria:[32]
         i. Enrolled in Medicaid,
         ii. SMI or SUD diagnoses,
         iii. Eligible for MMC (exception – does not include MMC enrollees permanently placed in a nursing home),
         iv. Age 21 or over, and
         v. Not involved in any OPWDD programs.
      b. Risk Factors: DOH looks at specific Medicaid behavioral health utilization to determine appropriateness of enrollment in HARP of targeted person[33]
   2. Protocols to allow service providers to refer individuals for HARP based on criteria other than Medicaid behavioral health usage data is under

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https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/related_links/docs/bh_policy_guidance_10-1-15.pdf (last visited Jul. 27, 2016).

[25] NYS Department of Health. Behavioral Health Transition to Managed Care, https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/ (last visited Jul. 27, 2016).

[26] NYS Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office of Children and Family Services. Children's Health and Behavioral Health Transition Update (July 1, 2016), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/docs/2016-07-01_kids_transition_update.pdf (last visited Jul. 27, 2016).

[27] RFQ at 13.

[28] *Id.* at 12.

[29] Partnership Plan at 29 (STC VI.8); RFQ at 36.

[30] RFQ at 11.

[31] Implementation Guidance at 5; RFQ at 16.

[32] RFQ at 17.

[33] Waiver Amendment application at 14-15; RFQ at 17-18.

development as of July 2016.[34] This will be important for people with SMI or SUD who have not used Medicaid services in the past such as those who are aging off of parents' insurance, individuals who are new to the State, and individuals experiencing a first episode of psychosis.

C. Enrollment
   1. Individuals identified by DOH as HARP eligible will receive notification and have an opportunity to enroll.
      a. MMC members whose MMC has an affiliated HARP → passively enrolled into sister HARP unless opt out or choose a different HARP.[35]
      b. MMC members whose MMC has no affiliate HARP → receive notice of availability of HARP. Must affirmatively enroll.[36]
      c. HIV SNP members notified of HARP, informed that HIV SNPs offer the same benefits.
   2. Once enrolled in HARP, members have 90 days to opt out. If they do not opt-out they are locked in to the enrollment for an additional 9 months.[37]

D. HARP benefits
   1. All MMC covered benefits, including physical health and newly carved-in behavioral health benefits.[38]
   2. Behavioral Health Home and Community Based Services (HCBS).[39]
   3. Enhanced care coordination, usually through a Health Home[40]
      a. All will be enrolled in a health home and assigned to a health home care manager.[41]
         i. Members can choose a different health home or health home care manager.
         ii. Members may choose not to enroll in a health home and receive care management from another source, such as the MCO care manager.[42]
      b. Health home care management includes "Comprehensive care management; care coordination and health promotion; Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; Individual and family support, which includes authorized representatives; Referral to community and social support services, if relevant; and The use of HIT [health information technology] to link services, as feasible and appropriate."[43]

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[34] New York State: Health and Recovery Plan (HARP) Adult Behavioral Health Home and Community Based Services (BH HCBS) Provider Manual at 4 (hereinafter "BH HCBS Manual"), available at http://www.omh.ny.gov/omhweb/bho/hcbs_manual.pdf (last visited Jul. 27, 2016).
[35] Partnership Plan at 27 (STC V.14).
[36] Id.
[37] Id.; Behavioral Health Transition to Managed Care, https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/
[38] Waiver Amendment application at 16.
[39] Partnership Plan at 4.
[40] Waiver Amendment application at 16-17.
[41] *Id.* at 16.
[42] Implementation Guidance at 42.
[43] NYS Department of Health. NYS Health Home Provider Qualification Standards For Chronic Medical and Behavioral Health Patient Populations,

c. Care Manger role re BH Home and Community Based Services (HCBS)[44]
    i. Health Home evaluates for Home and Community Based Services eligibility.
        (A) Health home conducts HCBS assessments even if individual chooses care management outside health home
    ii. Identify HCBS services to be received
    iii. Brokering to obtain and integrate HCBS services and supports
    iv. Advocacy to resolve issues that impede access to needed services
    v. Monitoring and reassessment of services based on changes in member's condition
    vi. Annual reassessment
d. Conducts person centered planning to determine care plan. Care plan developed regardless of whether get HCBS services.
    i. Identify individuals with co-morbidities such as mental illness, substance use disorder, and criminal justice involvement. For these individuals, coordinate services across the multiple systems in which they are involved.[45]

IV. HCBS Services (available in HARPs and HIV SNPs)

A. Eligibility for HCBS – meets at least one of these "Needs Based Criteria:"[46]
    a. Have at least moderate levels of needs as indicated through an assessment tool. New York's tool is the BH HCBS Eligibility Assessment, which contains a subset of questions from the NYS Community Mental Health Assessment tool.[47]
    b. Have a need for HCBS services as indicated by a face-to-face assessment and a risk factor of a newly-emerged psychotic disorder suggestive of Schizophrenia.
    c. Enrolled in a HARP and "previously met the needs-based criteria or has one of the needs based historical risk factors … AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need."

B. Assessment for determining HCBS to be provided.
    1. Originally the process for assessing an individual in HARP or HIV SNP for HCBS was cumbersome.
        a. It required an initial assessment of eligibility for HCBS services which took about half an hour to an hour, followed by a full community mental health assessment that could take up to 3 hours.[48]

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https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm; Waiver Amendment application at 16.

[44] Waiver Amendment application at 16-17.

[45] *Id.* at 17.

[46] *Id.* at 15.

[47] Implementation Guidance at 7.

[48] Adult BH HCBS Plan of Care Approval Workflow for Individuals Enrolled in HARPs or HARP Eligibles Enrolled in HIV SNPs (December 2015), *available at* https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_workflow.pdf (last visited Jul. 29, 2016).

b. This time consuming process caused delays in people actual accessing HCBS services.

2. An expedited process was developed in Spring 2016:[49]
   a. Health Home conducts NY HARP HCBS Eligibility Assessment and identifies HCBS eligibility tier (Tier 1 or Tier 2)
   b. Member's goals identified for the eligible tier of services
   c. Specific BH HCBS services are recommended.
   d. MCO is able to approve service determinations prior to the full assessment and development of a plan of care.
   e. Full Community Mental Health Assessment is completed within 90 days of NY HARP HCBS Eligibility Assessment

C. Available Behavioral Health HCBS Services:
   1. Tier 1
      a. Education Support Services[50]
         i. Services to support individuals returning to or attending school or a training program where the goal is obtaining employment.
         ii. Only provided if not otherwise available through the State's vocational rehabilitation agencies (ACCES-VR or Commission for the Blind) or under the Individuals with Disabilities Education Act.
         iii. Services are one-to-one
      b. Empowerment Services – Peer Supports[51]
         i. Peer-delivered, non-clinical services to promote coping skills and symptom management.
         ii. Face to face, one-on-one service
         iii. Caseload per peer: 1:20 max
      c. Pre-vocational Services[52]
         i. Learning and work experience to develop non-job-task-specific skills and soft skills to help with employability and employment.
         ii. Only provided if not otherwise available through the State's vocational rehabilitation agencies (ACCES-VR or Commission for the Blind) or under the Individuals with Disabilities Education Act.
         iii. Provided face-to-face and one-on-one
      d. Transitional Employment[53]
         i. Services to strengthen work record and work skills through learning, training and work experience.
         ii. Placements are part-time (15-20 hrs per week) and time-limited (6-9 months per year)

[49] NYS Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services. Managed Care Monthly Plan Meeting: Behavioral Health Update, May 12, 2016 at slide 9, *available at* http://www.leadingageny.org/?LinkServID=426FEB4A-F26F-D35F-20F20B13029D84A5 (last visited Jul. 27, 2016).
[50] BH HCBS Manual at 17-18.
[51] *Id.* at 19-21.
[52] *Id.* at 21-22.
[53] *Id.* at 22-24.

iii. Only provided if not otherwise available through the State's vocational rehabilitation agencies (ACCES-VR or Commission for the Blind) or under the Individuals with Disabilities Education Act.
iv. Provided face-to-face and one-on-one

e. Intensive Supported Employment[54]
   i. Services to help individuals obtain and maintain employment.
   ii. Only provided if not otherwise available through the State's vocational rehabilitation agencies (ACCES-VR or Commission for the Blind) or under the Individuals with Disabilities Education Act.
   iii. Provided face-to-face and one-on-one

f. Ongoing Supported Employment[55]
   i. Services provided to help maintain employment.
   ii. Only provided if not otherwise available through the State's vocational rehabilitation agencies (ACCES-VR or Commission for the Blind) or under the Individuals with Disabilities Education Act.
   iii. Provided face-to-face and one-on-one

g. Non-Medical Transportation[56]
   i. Transportation to non-medical locations that are necessary to meet a goal in the Plan of Care. This includes transportation to HCBS service locations as well as non-HCBS service locations.

2. Tier 2 (for Tier 2 eligible individuals, Tier 1 services are also considered Tier 2)[57]
   a. Psychosocial Rehabilitation[58]
      i. Rehabilitation counseling to assist with "compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with the behavioral health condition."
      ii. Provided face-to-face and one-on-one or through group setting.
      iii. Max Staff to Member Ratio: 1:20
   b. Community Psychiatric Support and Treatment[59]
      i. Supports and interventions to help individuals with serious mental illness achieve stability in daily living, finances, housing, employment, recovery/resilience, relationships and community integration
      ii. Provided face-to-face with individual as well as family or others important to the individual's life.
   c. Habitation[60]
      i. Services to help individuals with community living skills, including communication, self-care, self-advocacy, accessing transportation, performing activities of daily living.
      ii. Provided face-to-face and one-on-one.

[54] *Id.* at 24-26.
[55] *Id.* at 26-28.
[56] *Id.* at 33-34.
[57] Partnership Plan at 21 (STC V.2.b.)
[58] BH HCBS Manual at 6-8.
[59] *Id.* at 8-9.
[60] *Id.* at 10-11.

iii. Max Staff to Member Ratio: 1:20

d. Family Support and Training[61]
   i. Training and support to family and others close to the individual so that they have the knowledge and skills to help in the individual's recovery. Service is only provided if requested by the individual.
   ii. Provided face-to-face and one-on-one or in groups of family members of no more than 16.
   iii. Max Staff to Member Ratio: 1:15 (1:16, if group of family)

3. Services with No Tier
   a. Short-term Crisis Respite[62]
      i. Short term site-based interventions for individuals with a mental health or co-occurring diagnosis who need short term support to cope with a crisis or challenges of daily life that is causing escalating symptoms.
      ii. Services are in a site-based, homelike environment and are face-to-face. The site should hold no more than 8-10 individuals preferably in single rooms.
      iii. Available to all HARP enrollees and HARP eligible HIV SNP enrollees, regardless of whether approved for or receiving other HCBS.[63]
   b. Intensive Crisis Respite[64]
      i. Residential-based services for individuals experiencing acute escalation of symptoms to help stabilize and return to prior functioning or as a step down from inpatient hospitalization.
      ii. Available to all HARP enrollees and HARP eligible HIV SNP enrollees, regardless of whether approved for or receiving other HCBS.[65]
4. HCBS Dollar and Service Limitations
   a. HCBS Aggregate Dollar Limitations
      i. Tier 1 HCBS → $8,000 cap per person, per 12 months. Can go up to $10,000 with approval from OMH or OASAS.[66]
      ii. Tier 2 HCBS (includes Tier 1 & 2 services) → $16,000 cap per person, per 12 months. Can go up to $20,000 with approval from OMH or OASAS.[67]
   b. Crisis Respite → one week per service, up to 21 days in a year.[68]
   c. Non-Medical Transportation → $2,000 per calendar year cap. Transportation to HCBS services and travel by public transportation is not subject to the cap
   d. Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, and Habitation → combined hours of no more than 500/calendar year.[69]

[61] *Id.* at 12-13.
[62] *Id.* at 13-15.
[63] Partnership Plan at 21 (STC V.2.c).
[64] BH HCBS Manual at 15-17.
[65] Partnership Plan at 21 (STC V.2.c).
[66] *Id.* (STC V.3.a).
[67] *Id.* (STC V.3.b).
[68] *Id.* (STC V.3.c).
[69] BH HCBS Manual at 7.

e. Family Support and Training → no more than 40 hours in a calendar year.[70]
f. Education Support Services → supported education services limited to no more than 250 hours per year.[71]
g. Empowerment Services – Peer Supports → 500 hours/calendar year.[72]
h. Pre-Vocational Services and Transitional Supported Employment → no more than 250 hours and a duration of 9 months of service in a calendar year.[73]
i. Intensive Supported Employment and Ongoing Supported Employment → no more than 250 hours/calendar year.[74]

V. Continuity of Care During Transition of BH Benefit

A. Must provide a two year contract to all OMH or OASAS licensed or certified providers who are treating five or more of a plan's members at the time of transition. These providers must minimally get the FFS rate.[75]
B. Must allow members in a continuous episode of care to receive services for up to two years from an out of network provider who is licensed or verified by OMH/OASAS. The provider must receive the FFS rate. Utilization management can be used to review the duration or level of services.[76]
C. Plans must accept existing plans of care → No use of utilization management for 90 days after effective date of the behavioral health carve-in.[77]
   1. 90 Day Transition expired December 30, 2015 in NYC
   2. 90 Day Transition expires September 29, 2016 in the rest of the state

VI. Network Adequacy

A. Provider network must be the same for an insurance carrier's MMC as its HARP.[78]
B. Meet minimum network standards for each BH service.[79]
   1. Standard varies depending on whether county is rural or urban
   2. Standard varies by service type
C. Meet specific appointment availability standards for BH and HCBS services.[80]
D. Application of the current time and distance standard of 30 minutes/30 miles to behavioral health providers (standard can be greater than that if that is the "community standard").[81]

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[70] *Id.* at 13.
[71] *Id.* at 18.
[72] *Id.* at 20.
[73] *Id.* at 22.
[74] *Id.* at 25, 27.
[75] NYS OMH. Transitioning Adult Behavioral Health Services Into Medicaid Managed Care: Mental Health Contractual Provisions as of September 10, 2015, Att. A (hereinafter "Mental Health Contractual Provisions"); *see also* Partnership Plan at 29 (STC VI.8).
[76] Mental Health Contractual Provisions, Att. A.; RFQ at 58; Partnership Plan at 29 (STC VI.8).
[77] Mental Health Contractual Provisions, Att. A.
[78] RFQ at 51, 56.
[79] Mental Health Contractual Provisions, Att A; RFQ at 53-54.
[80] RFQ at 55-56.
[81] *Id.* at 56.

E. Must provide a two year contract to all OMH or OASAS licensed or certified providers who are treating five or more of a plan's members at the time of transition. These providers must minimally get the FFS rate.[82]
F. "If the plan determines that an alternate level of care is appropriate, but has not identified an appropriate provider of such care (either in network or out of network), the plan must continue to approve coverage of and continue to reimburse for services provided by the current provider."[83]
G. If the MCO network is unable to provide necessary medical services covered under the contract to a member, the MCO must adequately and timely cover the services out of network, for as long as the MCO is unable to provide them.[84]
H. Must contract with Federally Qualified Health Centers (previous requirement).[85]
I. Must contract with "essential" community providers including state operated programs.[86]

VII. Access to Services, Utilization Management and Medical Necessity

A. Member's primary care provider (PCP) may be employed at an OMH or OASAS program.[87]
B. No prior authorization or provider referral for:[88]
   1. Mental health and substance use disorder assessments (except ACT, inpatient psychiatric and partial hospitalization, HCBS)
   2. 72 hour supply of BH prescribed drugs (generally)
   3. 7 day supply for medication associated with management of opioid withdrawal or stabilization.
   4. Urgent or non-urgent ambulatory services delivered by OMH and OASAS outpatient clinics, integrated clinics, and medically supervised outpatient withdrawal and stabilization programs.
   5. Typical long-acting antipsychotics.
C. Authorization of mental health services must be made in accordance with approved utilization management criteria and guidelines.[89]
D. "If the plan determines that an alternate level of care is appropriate, but has not identified an appropriate provider of such care (either in network or out of network), the plan must continue to approve coverage of and continue to reimburse for services provided by the current provider."[90]
E. The state has provided detailed guidance on utilization management approaches MCOs expected to use for specific state plan behavioral health and HCBS services.[91]
F. Must provide for parity in the provision of behavioral health services.[92]

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[82] Mental Health Contractual Provisions, Att A; Waiver Amendment application at 8.
[83] Mental Health Contractual Provisions, Att A.
[84] NY Partnership Plan at 29 (STC VI.8).
[85] Waiver Amendment application at 8.
[86] *Id.*
[87] Mental Health Contractual Provisions, Att. A.
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] Implementation Guidance at 25-47.
[92] RFQ at 61.

G. Medical necessity is always the standard in Medicaid.
    1. Care, services and supplies "necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law."[93]
    2. For HCBS services, may be challenges to fitting services within the existing medical necessity determination.
        a. Use beneficial utilization management criteria in DOH/OMH/OASAS guidance to support arguments
        b. Argue medical necessity for HCBS has to be person centered and look at the whole plan of care and how services "will help the enrollee's needs to support sustained recovery from a serious mental illness or substance use disorder."[94]
        c. Argue services are medically necessary when it will help an enrollee "prevent, manage and ameliorate chronic health conditions and recover from serious mental illness or substance use disorder."[95]

VIII. Appeals, Hearings and Grievances

A. The right to internal and external (DFS) appeals, hearings and grievances is the same as it is for all other services provided through an MCO.
B. Hearable Issues
    1. Definitely Hearable (with aid-continuing)
        a. MCO denials, discontinuances, reductions of any service, including BH and HCBS denials
        b. Disagree with HCBS assessment or reassessment[96]
    2. Arguably Hearable
        a. HH or Care Manager failure to include or continue a service in a Plan of Care
    3. CMS specifically requires that "HARP enrollees are permitted to appeal any service denial decisions."[97]
C. Plan Decision Makers on Internal Appeals:[98]
    1. Decision makers on behavioral health denials, grievances, and appeals must be clinical peer reviewers with "clinical expertise in treating the member's condition or disease, stratified by age, for:
        a. "An appeal of a denial based on lack of medical necessity;
        b. "A grievance regarding plan denial of a request for an expedited appeal;
        c. "A grievance or appeal involving clinical issues; or
        d. "An appeal of a decision to authorize a service in an amount, duration, or scope that is less than requested.

[93] N.Y. Soc. Serv. Law, § 365-a(2).
[94] RFQ at 61.
[95] Implementation Guidance at 39.
[96] *Id.* at 8.
[97] Partnership Plan at 21 (STC V.2).
[98] RFQ at 64; Implementation Guidance at 55.

2. “Generally, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician for any denials. The reviewer should also have clinical experience relevant to the denial.”
    a. “A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment.
    b. “A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment.”

Health Insurance for Addiction & Mental Health Care

A Guide to the Federal Parity Law

Legal Action Center

www.lac.org

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About the Legal Action Center

The Legal Action Center is a non-profit law and policy organization whose mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas. For more information about the Legal Action Center, please visit www.lac.org

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1 Introduction

Substance use and mental health disorders affect many millions of Americans, devastating individuals, families, and communities across the country. In 2014, 21.5 million Americans aged 12 and older had a substance use disorder, and 43.6 million Americans aged 18 and over had a mental illness. One in ten Americans has a drug use disorder at some point in their lives, and 75 percent of them never receive treatment. Overdose deaths have skyrocketed over the past 15 years, with nearly 50,000 overdose deaths in 2014 alone.[1]

Yet health insurance coverage to prevent and treat these substance use and mental disorders remains elusive, even for those fortunate enough to have health insurance. Among those who felt they needed substance use disorder treatment and sought but did not receive it, lack of insurance coverage and inability to afford treatment were the leading reasons for not receiving care.[2] Insurance companies routinely erect obstacles to such coverage that do not exist for those seeking other medical and surgical care. For this reason, the United States Congress and many state legislatures, including New York's, have passed laws forbidding health insurers from making it more difficult to access care for mental health (MH) and substance use disorders (SUD) than for other medical and surgical conditions.

This guide explains patients' and providers' rights to health insurance coverage for MH and SUD services under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act[3] ("MHPAEA" or "federal parity law"), and touches on several other laws that impact patient and provider rights to insurance coverage for MH/SUD care.

This guide consists of 13 sections. Section 2 explains who should use this guide, and Section 3 provides a summary of the federal parity law. Section 4 provides a more in-depth explanation of the federal parity law, including a list of "red flags"—insurance practices to look out for as possible federal parity law violations. Because your legal rights vary depending on your type of health insurance plan, Section 5 provides a tool to help determine your plan type. Section 5 also has a Key that assigns each plan type a color, shape, and number, so you can follow yours through Sections 6 and 7. Section 6 provides information about some New York State laws that protect people seeking insurance coverage for MH/SUD. Section 7 explains how to enforce your rights under the federal parity law. Section 8 briefly discusses types of health insurance plans *not* protected by the federal parity law. The Glossary in Section 9 explains terms used throughout this guide. These terms also appear in red text throughout the guide with hyperlinks to the Glossary. Section 10 lists some additional rights you have under other laws. Section 11, the endnotes, contains notes and references. Section 12 provides links to helpful resources, and Section 13 contains sample appeals, complaints, and letters you can use to enforce your rights.

This guide provides information, but not legal advice. Please consult a lawyer for legal advice.

2 Who Should Use This Guide?

This guide can benefit people who want their health insurance plans to pay (or help pay) for mental health (MH) or substance use disorder (SUD) care. It is also for their advocates, treatment providers, families, and other loved ones.

This guide will help you understand your right to health insurance coverage for MH and SUD care, including whether your insurer is required to pay for your MH or SUD care, and what to do if it is refusing to pay.

This information can be confusing! If you have questions after using this guide, the Legal Action Center's free parity hotline for New York SUD treatment providers, advocates, and lawyers might be of help. Visit http://lac.org/what-we-do/substance-use for more information.

3 Summary of the Federal Parity Law

This guide explains patients' and providers' rights to health insurance coverage for MH and SUD services under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA" or "federal parity law"), and touches on several other laws that impact the right to insurance coverage for MH/SUD care. Below is brief background about the law, a summary of its main requirements, and a description of which health insurance plans must follow the law.

A. Background on the Federal Parity Law

The federal parity law was passed into law in 2008, to end health insurance discrimination against people with mental health and substance use disorders so that more people could access the care they need. The 2008 federal parity law does *not* require health insurance plans[4] to cover services for mental health and substance use disorders; it requires plans that *do* cover those services to cover them equally with other medical and surgical services.

In 2009, the Children's Health Insurance Program Reauthorization Act ("CHIPRA") extended federal parity protections to Children's Health Insurance Programs, including New York's Child Health Plus ("CHP"). In 2010, the Patient Protection and Affordable Care Act[5] ("ACA") required more types of health insurance plans to follow the federal parity law. The ACA also required some types of health plans to provide MH and SUD benefits. **The combined effect of the federal parity law and the ACA is that nearly**

all public and private health insurance plans in the U.S. that choose to provide MH and SUD benefits must provide them equally with other medical and surgical benefits, and many of those health plans are required to provide MH and SUD benefits.[6] An estimated 62 million Americans have gained insurance protections for MH and SUD services through these laws.

After the U.S. Congress passed the parity law, the federal agencies tasked with enforcing it also were required to issue regulations explaining how that law should be implemented. In November 2013, final regulations implementing the federal parity law were issued by the U.S. Department of Labor ("DOL"), the U.S. Department of Treasury ("Treasury"), and the U.S. Department of Health and Human Services ("HHS").[7] In March 2016, final regulations implementing the federal parity law for Medicaid and CHIP were issued by the Centers for Medicare and Medicaid Services ("CMS"), which is part of HHS.[8]

B. The Federal Parity Law's Main Requirements

In a nutshell, the federal parity law requires the comparison of MH and SUD benefits to other medical and surgical benefits to make sure they are covered equally. Most, but not all, health insurance plans are required to follow the federal parity law (read more in Section 3-C). **Plans that are required to follow the federal parity law must comply with these requirements:**

1) Plans may not have any separate financial requirements or treatment limitations that apply only to MH or SUD benefits.[10]

Financial requirements are what *you* have to pay, including deductibles, co-payments, co-insurance, and out-of-pocket expenses. They do not include annual limits and aggregate lifetime limits.

Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. There are two types of treatment limitations:

(a) Quantitative Treatment Limitations are limitations with a number, such as limits on the number of days or visits or limits on the frequency of treatment.
(b) Non-Quantitative Treatment Limitations (NQTLs) are those that are not expressed numerically, but that otherwise limit the scope or duration of treatment. This includes: medical necessity criteria; pre-authorization requirements; prescription drug formulary design; "fail first" or step therapy policies; standards for provider admission to participate in-network; determination of usual, customary, reasonable amounts for provider payments; exclusions based on failure to complete a course of treatment; scope of benefits; and restrictions based on geographic location, facility type, or provider specialty.

Example of Separate Financial Requirements/ Treatment Limitations: Your health plan imposes a $500 deductible on MH/SUD services. The plan does not impose any deductible on medical/surgical services. This likely violates the federal parity law, because the plan is has a separate financial requirement (the deductible) that applies only to MH/SUD benefits and not to medical/surgical services.

2) Plans may not apply financial requirements or treatment limitations to MH or SUD benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical or surgical benefits.[10]

What does that mean?

First, "predominant" means the most common or frequent type of treatment limitation or financial requirement. The predominant level of a financial requirement or quantitative treatment limitation is the one that applies to more than one-half of the medical/surgical benefits in a classification that are subject to that financial requirement or quantitative treatment limitation. (For non-quantitative treatment limitations (NQTLs), there is no mathematical formula for determining what is predominant.[11] Instead, the federal parity law says plans may not impose an NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying to MH/SUD benefits are comparable to, and applied no more stringently than, the ones used in applying the NQTL to medical/surgical benefits in the classification.)[12]

Second, "substantially all" means at least two-thirds of all medical/surgical benefits in a classification of benefits.

Example of More Restrictive Treatment Limitation: Your health plan only allows 30 psychologist visits per year. There is no similar visit limit on the medical/surgical side (for example, you can visit your primary care doctor as often as you want). This may violate the federal parity law, since your plan is placing a treatment limitation (visit limits) on MH/SUD benefits (psychology services) that is not placed on medical/surgical benefits (primary care).

3) Plans must provide out-of-network benefits for MH and SUD services if they are provided for medical and surgical services.[13]

Example of Out-of-Network Benefits: Your health plan allows you to visit both in-network and out-of-network providers for medical/surgical needs – for example, an in-network or out-of-network neurologist. However, your plan only allows you to visit in-network health care providers for MH/SUD treatment (for example, only in-network psychiatrists). This *likely* violates the federal parity law, because the law says if a plan provides out-of-network benefits for medical/surgical services (like the neurologist), it must provide out-of-network benefits for MH/SUD services (like the psychiatrist).

Furthermore, the ACA forbids health plans that provide "essential health benefits" from placing annual or lifetime limits on these benefits.[14] In New York State, essential health benefits include inpatient, outpatient, and residential mental health and substance use disorder treatment, as well as medications like methadone and buprenorphine (e.g., Suboxone).[15] This means that if your health plan covers inpatient or outpatient MH/SUD treatment, those benefits may not be subject to annual or lifetime limits.

Example of Essential Health Benefits: Your health plan will not pay more than $1,000 per year for outpatient substance use disorder treatment. This likely violates the ACA. Here's why: New York State considers outpatient SUD treatment an "essential health benefit," and your plan is placing an annual limit on that benefit ($1,000 per year).

4) Plans must disclose the following:

- Medical necessity criteria for MH and SUD benefits: These are the criteria plans use to decide whether the care you are asking them to pay for is medically necessary. Plans must disclose these criteria to you and/or your provider, if requested. Plans must also disclose this information to people considering joining the plan, if they request it.
- Denial reason: Plans must disclose the reason for denying reimbursement or payment for MH or SUD services, if you request it (or as otherwise required).[16]

All of these requirements are discussed in more detail in Section 4.

C. Different Rules for Different Types of Plans

Almost all—but not all—health insurance plans *must comply* with the federal parity law. Your rights, and the process for enforcing them, depend on your type of health plan. To find out your plan type, use our tool, "Determining Your Type of Health Insurance Plan." You can also call your health plan and ask what type of

plan you have, or contact the New York Department of Financial Services, which regulates insurers in New York State, at 1-800-342-3736.

The following types of health insurance plans must comply with the federal parity law:

1) Plans that ***large employers*** (51 or more employees) provide to their employees.

2) Most plans that ***small employers*** (50 or fewer employees) provide to their employees, including those that were bought on the health insurance marketplace (New York State of Health) and many that were bought outside the marketplace.

> **NOTE:** Small group plans that are "grandfathered" are not required to comply with the federal parity law, but there are very few of these plans remaining. If you have a grandfathered plan, your plan documents will tell you this; you can also ask your health plan whether it is grandfathered. For more information about parity-related protections for people whose plans are not covered by the federal parity law, see Section 8.

3) ***Individual*** plans.

4) Some ***Medicaid*** plans, including all Medicaid managed care plans and Medicaid plans for the "expansion population" under the ACA (including Alternative Benefit Plans).

5) Children's Health Insurance Program ***(CHIP)*** plans, known in New York as Child Health Plus.

6) **State and local *government*** employer plans.

> **NOTE:** State and local government plans that are self-insured can choose to "opt-out" of complying with the federal parity law, but as of this writing we are not aware of any New York plans that have done so. For more information about parity-related protections for people whose plans are not covered by the federal parity law, see Section 8.

7) ***Church***-sponsored plans.

> **NOTE:** Church-sponsored health plans can choose to "opt-out" of complying with the federal parity law. For more information about parity-related protections for people whose plans are not covered by the federal parity law, see Section 8.

8) ***Federal Employee Health Benefits (FEHB) Program*** plans. Though these plans, which provide health insurance to federal government employees, are not covered by

the federal parity statute, the U.S. Office of Personnel Management issued a letter directing them to comply with it.[17]

Most individual and small group plans, as well as Medicaid Alternative Benefit Plans, are additionally required by the ACA to provide a package of Essential Health Benefits, which include MH/SUD benefits.

A note about Medicaid Managed Care plans: Many New Yorkers who have Medicaid are already enrolled in Medicaid Managed Care plans. Moving forward, as part of New York's Medicaid Redesign, nearly all Medicaid recipients in New York will be moved into managed care, rather than the traditional fee-for-service model.[18] Although MH and SUD benefits have historically been "carved out" of New York's Medicaid Managed Care programs and provided on a fee-for-service basis, the state will be moving MH and SUD care into managed care beginning in 2015 (for New York City) and 2016 (for the rest of the state).[19] Furthermore, final regulations implementing the federal parity law for Medicaid and CHIP extend federal parity protections to anyone enrolled in Medicaid Managed Care—regardless of whether their behavioral health benefits are provided through the managed care plan or through another mechanism like fee-for-service.[20] Therefore, by 2016, most New Yorkers who receive Medicaid will be covered by the federal parity law because most New Yorkers will be enrolled in Medicaid Managed Care.

A note about Child Health Plus plans: The final regulations, which explain in more detail how the federal parity law applies to Children's Health Insurance Program (CHIP) plans, including New York's Child Health Plus (CHP), say that if a state's CHIP plan covers Early and Periodic Screening, Diagnostic, and Treatment (known as EPSDT) in compliance with federal law, the CHIP plans will be presumed to comply with the federal parity law. Under these regulations, New York's CHP plan would be presumed to comply with the federal parity law because it does cover EPSDT.[21] However, you may still report concerns about possible violations of the federal parity law by your CHP plan. See Section 7 for more information about what to do if your plan may be violating the federal parity law.

The following health insurance plans are not required to comply with the federal parity law:

1) **Medicare** plans;
2) *Traditional* ***Fee-for-service*** **Medicaid** coverage, in which neither MH/SUD or medical/surgical benefits are provided through a managed care plan;
3) ***Small employer*** plans (50 or fewer employees) that are "grandfathered" (created before March 23, 2010, with no significant changes since then);
4) ***TriCare*** plans[22];
5) ***Retiree-only*** plans; and
6) *Plans that have successfully requested an* ***exemption****.* The following types of plans may request an exemption from the federal parity law:
    - » Employer-provided plans, where the employer can show that the federal parity law's requirements have increased its health care costs by a certain amount (this is extremely rare)[23]; and
    - » Self-insured plans provided by state and local government employers.[24]

The following chart summarizes which plans must follow the federal parity law, as well as those required to offer MH/SUD benefits and comply with the federal parity law:

What Types of Plans Must Follow Federal Parity Law and/or Offer MH/SUD Benefits?		
***If* Offer MH/SUD Benefits, Must Comply with Parity**	**Must Offer MH/SUD Benefits *and* Comply with Parity**	**Not Required to Offer MH/SUD or Comply With Parity**
» Large group plans	» Individual & small group plans sold on the New York State of Health marketplace	» Traditional (fee-for-service) Medicaid
» Grandfathered individual plans sold outside the New York State of Health marketplace	» Non-grandfathered individual & small group plans sold outside the New York State of Health marketplace	» Grandfathered small group plans sold outside the New York State of Health marketplace
» Medicaid Managed Care plans	» Medicaid plans covering the ACA expansion population, including Alternative Benefit Plans (ABPs)	» Plans that received a cost increase exemption
» State & local government plans*		» Medicare
» Child Health Plus Plan (CHP)		» Retiree-only plans
» Church-sponsored plans*		» TriCare†

* Church plans and self-insured state and local government plans can choose to "opt-out." As of this writing, we are not aware of any New York plans that have opted out, although there are plans in other states that have done so. If you are an employee of a state or local government and want to know whether your employer-sponsored plan has opted out, you may contact the U.S. Department of Health and Human Services at (877) 267-2323 ext. 61565 or phig@cms.hhs.gov to find out.

† Although TriCare plans are not required to comply with the federal parity law, the U.S. Department of Defense has proposed regulations to align TriCare plans with the requirements of the federal parity law. If these regulations are finalized, TriCare plans will have greater parity between MH/SUD and other medical/surgical benefits.[26]

4 The Federal Parity Law: The Details

A. Financial Requirements & Treatment Limitations

As discussed in Section 3, the federal parity law prohibits health plans from having separate financial requirements for MH/SUD benefits. It also prohibits them from applying financial requirements and treatment limitations to MH and SUD benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical or surgical benefits (this is referred to as the "predominant/substantially all test").[26]

The multi-layered process to determine whether a parity violation has occurred can be daunting. Figuring out whether your health plan has certain financial requirements that it applies only to MH/SUD benefits is fairly straightforward (for example, an annual visit limit for psychologist visits but no similar limit on the medical/surgical side). But figuring out whether your plan applies financial requirements and treatment limitations more restrictively to MH/SUD benefits than to the "predominant" financial requirements and treatment limitations applied to "substantially all" medical/surgical benefits is more complicated. It is not the individual patient's job to do this analysis! You can ask an advocate for assistance. You can also report possible violations of the law—such as the "red flags" discussed on page 24—to government agencies without getting into the level of detail provided in this guide. This section will explain in detail how to figure out if your plan may be violating the federal parity law. **If this seems confusing or overwhelming, don't give up!** In fact, you can skip this section altogether and read Section 7 to learn what to do if you think your plan *might* be violating the federal parity law. But those readers who want more detail should read on.

Remember, the federal parity law says:

> **Health plans may not apply financial requirements or treatment limitations to MH or SUD benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical or surgical benefits.**[27]

(i) ***Classifications***

The regulations explain that the comparison between MH/SUD and medical/surgical financial requirements and treatment limitations should be made across classifications of benefits. The regulations require health insurance plans to classify all of their MH, SUD, and medical/surgical benefits into one of six classifications:

1) Inpatient, in-network
2) Inpatient, out-of-network
3) Outpatient, in-network
4) Outpatient, out-of-network
5) Emergency care
6) Prescription drugs

Note that the regulations applying MHPAEA to Medicaid and CHIP use the same system, but with four classifications rather than six, because the Medicaid/CHIP classifications have no in-network vs. out-of-network distinction. The four classifications into which Medicaid and CHIP plans must classify their benefits are: (1) inpatient, (2) outpatient, (3) emergency care, and (4) prescription drugs.[28]

All of a plan's benefits must be placed into one of the six (or, in the case of Medicaid and CHIP, four) classifications, including "intermediate" levels of care that do not necessarily fit obviously into one of the classifications. Intermediate levels of care include things like residential treatment, intensive outpatient, and partial hospitalization. To find out how your plan classifies a particular service or benefit, you may try asking the plan directly. (See Section 4-B, "Disclosure & Transparency Requirements," concerning what information your plan is required to share with you.)

Therefore, when figuring out whether your plan applies financial requirements and treatment limitations more restrictively to MH/SUD benefits than to medical/surgical benefits, you should compare benefits within the same classification. The financial requirements and treatment limitations applied to MH/SUD benefits *in a classification* cannot be more restrictive than the predominant ones applied to substantially all medical/surgical benefits *in that same classification*.[29]

Examples of Classifications

MH/SUD	Medical / Surgical
» Inpatient: Detoxification	» Inpatient: Appendicitis
» Outpatient: Psychologist visit	» Outpatient: Primary care visit for flu
» Emergency Care: ER for overdose	» Emergency Care: ER for broken leg
» Prescription Drugs: Suboxone	» Prescription Drugs: Blood pressure medication

Example of Classifications: Your health plan only covers "in-network" providers. It puts both psychologist and optometrist visits in the "outpatient" classification. It puts both detoxification and heart surgery in the "inpatient" classification.

You want to know whether your plan's co-payments (a "financial requirement") comply with the federal parity law. You should compare the co-payment you are charged for a psychologist visit to the one you are charged for an optometrist visit, because both are in the "outpatient" classification. You should not compare the co-payment for a psychologist visit to the co-payment for heart surgery, because they are in different classifications. (The psychologist is "outpatient" and the heart surgery is "inpatient.") You must compare MH/SUD financial requirements and treatment limitations to those applied to medical/surgical services in the same classification.

When comparing financial requirements or treatment limitations in the same classification, you should compare them by type of financial requirement or treatment limitation.[30]

A type of financial requirement or treatment limitation means the nature of the financial requirement or treatment limitation. Different types of financial limitations include deductibles, co-payments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual limits, episode limits, and lifetime day and visit limits. For examples of different types of non-quantitative treatment limitations (NQTLs), see the NQTL definition in the Glossary.

Example of Types: Your health plan only covers "in-network" providers. It requires you to pay co-insurance and co-payments (two "types" of financial requirements), depending on what kind of service you are receiving.

You want to know whether your plan's financial requirements comply with the federal parity law. You should compare MH/SUD co-payments to medical/surgical co-payments within the same classification (for example, within the "outpatient, in-network" classification), because they are both the same "type" of financial requirement. You should not compare MH/SUD co-payments to medical/surgical coinsurance within the same classification, because co-payments and coinsurance are two *different* "types" of financial requirements, and you must compare the *same* type.

Furthermore, if the plan provides MH or SUD benefits in *any* classification of benefits, it must provide MH or SUD benefits in *every* classification in which medical/surgical benefits are provided.[31] This includes a requirement that the plan provide out-of-network MH/SUD benefits if it provides out-of-network medical/surgical benefits.[32] This means plans that provide *any* MH/SUD benefits must usually provide a *full scope* of MH/SUD benefits.

Example of Classifications: Your health plan only covers "in-network" providers. It covers both inpatient and outpatient services for medical/surgical care. For example, it covers outpatient visits to your primary care doctor when you have the flu, and it covers inpatient stays at the hospital when you have appendicitis. Your plan also covers outpatient MH/SUD treatment. For example, it covers your outpatient addiction counseling. However, the plan will not pay for inpatient detoxification services.

Your health plan may be violating the federal parity law. The plan offers MH/SUD benefits in the "outpatient, in-network" classification (which is how the plan classifies outpatient addiction counseling), but not in the "inpatient, in-network" classification (which is how the plan classifies inpatient detoxification). However, the plan offers medical/surgical benefits in both the "outpatient, in-network" classification (which is how it classifies a visit to your doctor when you have the flu) *and* the "inpatient, in-network" classification (which is how it classifies your hospital stay for appendicitis). Because the plan offers MH/SUD benefits in *some* classifications ("outpatient, in-network"), the parity law requires it to offer them in *every* classification in which it offers medical/surgical benefits ("outpatient, in-network" and "inpatient, in-network").

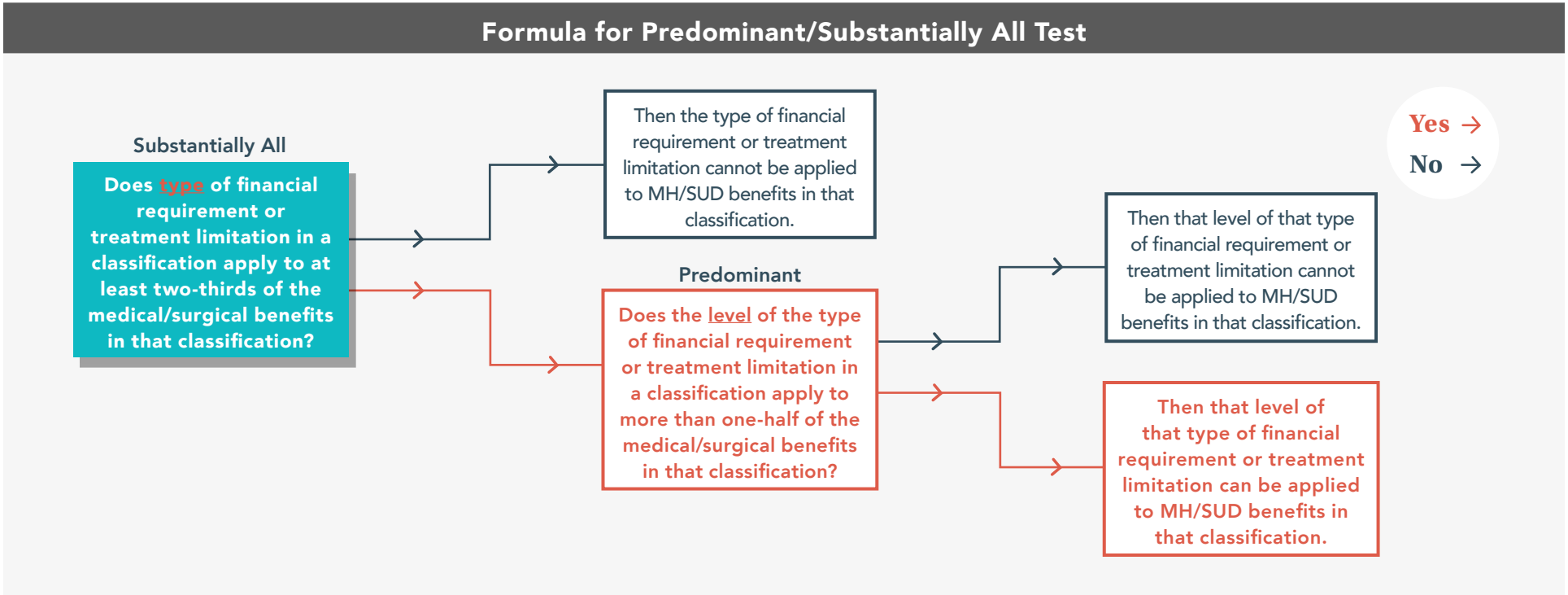
(ii) *Mathematical formula for predominant/substantially all test.*

For financial requirements and *quantitative* treatment limitations, the parity regulations provide a mathematical formula to determine whether a health plan that restricts access to MH/SUD benefits is violating the law's predominant/substantially all test.[33]

- Under the mathematical formula, a type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least *two-thirds* of those benefits. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then it cannot be applied to MH/SUD benefits in that classification.[34]

- Once you have determined that a type of financial requirement or treatment limitation applies to substantially all (at least two-thirds) of the medical/surgical benefits in a classification, you must determine whether the level of that type of financial requirement is the predominant one. The level of a type of financial requirement or treatment limitation is predominant if it applies to more than *one-half* of the medical/surgical benefits in a classification.[35]

Therefore, the basic mathematical formula looks like this:



If you are interested in additional details about how the mathematical formula works, you can find them in the regulations.[36]

Non-quantitative treatment limitations are also subject to the "predominant/substantially all test." However, unlike financial requirements and *quantitative* treatment limitations, this test is not decided by a mathematical formula for *non-quantitative* treatment limitations. This is because *non-quantitative* treatment limitations are, as a rule, not expressed numerically. Instead, the regulations state that plans may not impose a non-quantitative treatment limitations on MH/SUD benefits unless any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to MH/SUD benefits are comparable to, and applied no more stringently than, those used in applying the non-quantitative treatment limitation to medical/surgical benefits.[37] Non-quantitative treatment limitations are discussed in more detail in Section iii, below.

(iii) ***Non-quantitative treatment limitations***

Remember, there are two types of treatment limitations under the federal parity law:

- Quantitative treatment limitations, and
- Non-quantitative treatment limitations (NQTLs).

Recall that non-quantitative treatment limitations (NQTLS) are treatment limitations that are not expressed numerically but that otherwise limit the scope or duration of treatment. Examples of NQTLs include: medical management standards (like medical necessity criteria); formulary design for prescription drugs; network tier design (for plans that have multiple network tiers); standards for provider admission to participate in-network, including reimbursement rates; methods for determining usual, customary, and reasonable charges for a service; fail-first or step-therapy policies; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, or provider specialty.

As with the quantitative treatment limitations (and financial requirements) discussed above, the federal parity law requires NQTLs to be applied comparably to MH/SUD benefits and medical/surgical benefits. Federal parity law prohibits health insurance plans from imposing a NQTL on MH/SUD benefits in any classification (see Section (i)), unless the plan's processes, strategies, evidentiary standards, and other processes used in applying the NQTL to MH/SUD benefits are comparable to, and applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in that classification.[38] **The following examples are just some of the ways in which NQTLs do and do not violate the federal parity law.**

Examples of Non-Quantitative Treatment Limitations

Example 1 of NQTLs: Your health plan requires you to get prior authorization that a treatment is medically necessary for all inpatient medical/surgical benefits and all inpatient MH/SUD benefits. In practice, your plan routinely approves *seven* days of inpatient benefits for medical/surgical conditions, after which the patient's attending provider must submit a treatment plan for approval. On the other hand, your health plan routinely approves only one day of inpatient MH/SUD benefits, after which the patient's attending provider must submit a treatment plan for approval.

Your plan violates the federal parity law, because it is applying a stricter non-quantitative treatment limitation in practice to MH/SUD benefits than is applied to medical/surgical benefits.

Example 2 of NQTLs: Your health plan applies concurrent review to types of inpatient care where the length of stay tends to vary greatly. The plan uses a mathematical formula to determine which types of inpatient care have a lot of variation. In practice, after applying the formula, the plan applies concurrent review to 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions, because the formula found more variation in MH/SUD inpatient stays than in medical/surgical.

Your health plan complies with the federal parity law because the evidentiary standard used by the plan is applied no more stringently for MH/SUD benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Examples of Non-Quantitative Treatment Limitations

Example 3 of NQTLs: Your health plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs with a Food and Drug Administration black box warning label (for drugs carrying a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan provides coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

Your health plan violates the federal parity law. Although the standard for applying a non-quantitative treatment limitation is the same for both MH/SUD benefits and medical/surgical benefits (whether a drug has a black box warning) it is not applied in a comparable manner. The plan's unconditional exclusion of antidepressant drugs with a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 4 of NQTLs: Your health plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient SUD treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

Your plan violates the federal parity law. Although the same non-quantitative treatment limitation—medical appropriateness—is applied to both MH/SUD benefits and medical/surgical benefits, the plan's unconditional exclusion of SUD treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Examples of Non-Quantitative Treatment Limitations

Example 5 of NQTLs: Your health plan will only approve SUD treatment at an inpatient facility if you "fail first" at outpatient SUD treatment. There is no similar "fail first" requirement for medical/surgical benefits.

Your health plan may be violating the federal parity law. The plan is imposing a non-quantitative treatment limitation that restricts access to SUD treatment based on a "fail first" requirement. Because there is no comparable exclusion for medical/surgical benefits, this exclusion may not be applied to SUD benefits.

Example 6 of NQTLs: Your health plan generally provides coverage for medically appropriate medical/surgical benefits as well as MH/SUD benefits. Your plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the State where the policy is written. There is no similar exclusion for medical/surgical benefits within the same classification.

Your plan violates the federal parity law. The plan is imposing a non-quantitative treatment limitation that restricts benefits based on geographic location. Because there is no comparable exclusion for medical/surgical benefits, this exclusion may not be applied to MH/SUD benefits.

(iv) ***Prescription drugs***

The federal parity law applies to prescription drug benefits as well, meaning that plans must provide equal coverage for MH/SUD and medical/surgical prescription drugs.

A health plan is permitted to create a single formulary for prescription drugs, and then break that formulary into tiers based on reasonable factors. These are called "multi-tiered" prescription drug benefits.

Plans may impose different levels of financial requirements on different tiers of prescription drug benefits. (For example, generic prescriptions may cost less than brand-name prescriptions.) The plan must base these prescription benefit tiers on reasonable factors such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. The federal parity law requires plans to determine prescription benefit tiers without regard to whether a drug is generally prescribed for MH/SUD benefits or medical/surgical benefits.[39]

Example of Prescription Drugs: Your health plan excludes from its prescription coverage all medications for addiction treatment—including methadone, buprenorphine, and naltrexone. There is no similar exclusion on the medical/surgical side. Your health plan may be violating the federal parity law because it is excluding all prescription drug benefits for SUD, contrary to the law's requirement that plans determine prescription benefits without regard to whether a drug is generally prescribed for MH/SUD or medical/surgical conditions.

(v) ***Sub-classifications***

Plans are also permitted to create multiple tiers of in-network providers. For example, a plan could have an in-network tier of "preferred providers," who are the least expensive, and an in-network tier of "participating providers," who are more expensive. If a plan divides its in-network providers into multiple tiers, these tiers are considered sub-classifications, and the tiers must be based on reasonable factors such as quality, performance, or market standards. Tiers must be created without regard to whether a provider provides MH/SUD services or medical/surgical services. If a health plan establishes this type of sub-classification, it must then compare MH/SUD and medical/surgical benefits across *sub*-classifications (rather than classifications) to ensure that any financial requirements and treatment limitations imposed on MH/SUD benefits in that sub-classification are imposed no more restrictively than the predominant financial requirements and treatment limitations imposed on substantially all medical/surgical benefits in that sub-classification.[40] (Note that this type of sub-classification doesn't apply to Medicaid and CHIP plans. See Section 4-A-i for more information.)

Health plans are also permitted to create a sub-classification separating office visits from all other outpatient services. Office visits could include, for example, physician visits, while other outpatient services could include things like outpatient surgery, facility charges for day treatment centers, and laboratory charges.[41] As with sub-classifications created for in-network tiers, MH/SUD and medical/surgical benefits would then be compared across *sub*-classifications, rather than across classifications.

Health insurance plans are not permitted to create any other types of sub-classifications aside from the two noted here. For example, a plan may not create separate sub-classifications for generalists and specialists.[42]

The list of classifications for Medicaid and CHIP, together with the permitted sub-classifications, looks like this:

Classifications & Sub-Classifications (Medicaid & CHIP):		
1	**Inpatient**	a. Sub-classification permitted: office visits versus other outpatient services
2	**Outpatient**	
3	**Emergency care**	
4	**Prescription Drugs**	

The list of classifications for private insurance, together with the sub-classifications, looks like this:

Classifications & Sub-Classifications (Private Insurance)		
	Inpatient, in-network	a. Sub-classification permitted: tiers of in-network providers
2	**Inpatient, out-of-network**	
3	**Outpatient, in-network**	a. Sub-classification permitted: tiers of in-network providers b. Sub-classification permitted: office visits versus other outpatient services
4	**Outpatient, out-of-network**	a. Sub-classification permitted: office visits versus other outpatient services
5	**Emergency Care**	
6	**Prescription Drugs**	

(vi) Cumulative financial requirements and treatment limitations

The federal parity law also says private health insurance plans may not apply any cumulative financial requirements or cumulative quantitative treatment limitations to MH/SUD benefits in a classification that accumulate separately from cumulative financial requirements and treatment limitations for medical/surgical benefits in that classification.[43] Medicaid and CHIP plans are also forbidden from applying separate cumulative financial requirements to MH/SUD and medical/surgical benefits. However, Medicaid and CHIP plans may apply separate cumulative quantitative treatment limitations to MH/SUD benefits and medical/surgical benefits.[44]

"Cumulative financial requirements" are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts. Examples include deductibles and out-of-pocket maximums.

"Cumulative quantitative treatment limitations" are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Example 1 of Cumulative Financial Requirement: An employer-provided health plan imposes a combined annual $500 deductible on all medical/surgical, MH, and SUD benefits.

The combined annual deductible (a cumulative treatment requirement) complies with the federal parity law because it accumulates together, not separately, for medical/surgical and MH/SUD.

Example 2 of Cumulative Financial Requirement: An employer-provided health plan imposes an annual $250 deductible on all medical/surgical benefits and a separate annual $250 deductible on all MH/SUD benefits.

This health plan violates the federal parity law, because it has separate annual deductibles (a cumulative financial requirement) for MH/SUD benefits and medical/surgical benefits.

B. Disclosure & Transparency Requirements

The federal parity law, and other federal and state laws, give you the right to certain information from your health plan. Requesting this information can help you understand what benefits you are entitled to; it can also help you learn whether your health plan is complying with the federal parity law.

The federal parity law requires your health plan to provide you with the criteria it uses to make medical necessity determinations with respect to *MH/SUD* benefits, upon request. Your provider is also entitled to this information.[45] But without the medical necessity criteria for *medical/surgical benefits*, it is difficult to determine whether your plan is complying with the federal parity law (see Section (ii)). Fortunately, other federal law requires most health plans to provide you with their medical necessity criteria for both MH/SUD benefits *and* other medical/surgical benefits, upon request.[46]

Federal laws, including ERISA and the ACA, also require most health plans covered by the federal parity law to provide you with the following information, upon request:

1) Processes, strategies, evidentiary standards, and other factors used to apply a non-quantitative treatment limitation for medical/surgical benefits and mental health or substance use disorder benefits under the plan.[47]
2) Upon appeal of an adverse benefit determination, all documents, records, and other information relevant to your claim.[48]
3) Whether, and under what circumstances, existing and new prescription drugs are covered.[49]

In addition, the federal parity law requires your health plan to provide you with the reason for any denial of reimbursement or payment for MH/SUD services, upon request or as required by other laws and policies.[50]

If you have a Medicaid plan, you are also entitled to receive information as part of the fair hearing process. To learn more about fair hearings, see Section 7. The public is also entitled to certain information about Medicaid plans, and can access this information by filing a request under the Freedom of Information Law.[51]

Although health plans are required by law to provide this information, not all plans comply with the law. For example, some plans say they cannot disclose their medical necessity criteria because that information is proprietary. However, the federal government has made clear that this is not a permissible reason to withhold information. Both the U.S. Department of Labor and the Centers for Medicare and Medicaid Services have released Frequently Asked Questions addressing this issue, making clear that plans must release information "regardless of any assertions as to the proprietary nature or commercial value of the information."[52]

When requesting the information you are entitled to by law, you should keep track of your requests and, if your health plan refuses to provide the information, you should complain to the appropriate government agencies, as discussed in Section 7.

C. Red Flags

As discussed in earlier in this guide, figuring out whether your health insurance plan is violating the federal parity law can be complicated and is not something you have to do on your own!

There are government agencies whose job it is to determine whether health plans are violating the federal parity law and advocates who can help you.

Here is what you *can* do. If you see a "red flag" from the chart below, your plan may be violating parity; you may want to report it to the government or another organization so they can do the in-depth analysis required under the law. (See Section 7 to learn more about what to do if you think your plan may be violating the federal parity law.)

Red Flags

Coverage Limitations	Different Co-Payments, Deductibles, and Caps	Barriers to Receiving Covered Services
No coverage of residential MH/SUD treatment. No coverage of medication-assisted treatment for addiction, such as methadone, buprenorphine (e.g., Suboxone), and injectable naltrexone (e.g., Vivitrol). Limitations on coverage of medication-assisted treatment (for example, paying for only one year of methadone treatment). Limits on the number of days of MH/SUD treatment, or on the number of visits to a MH/SUD provider. No coverage of preventative screenings and services for MH/SUD when such services are covered for other medical/surgical conditions. No coverage of recovery supports for MH/SUD when chronic disease management services are covered for other medical/surgical conditions.	Higher co-payments for routine MH/SUD visits than for routine medical/surgical visits. A separate deductible for MH/SUD services. Limits on how much your health plan will pay per year, or during your lifetime, for MH/SUD benefits.	Requirement that you "fail first" at a lower level of treatment (such as outpatient) before being approved for a higher level of treatment (such as inpatient). Refusing to cover MH/SUD treatment because you failed to complete previous treatment or because "the patient is not improving." Requiring frequent pre-authorization or concurrent review for MH/SUD services (for example, only approving a few days of services at a time before requiring another pre-authorization). Your plan says it covers a particular service, such as outpatient SUD treatment, but has no providers for that service in its network. Refusal to provide information, like medical necessity criteria, when you request it. Insufficient and/or incorrect information in denial letters. Examples include: no information about the criteria and evidence used to make the decision; application of incorrect criteria (such as denying treatment based on patient's lack of withdrawal symptoms if that is not in the plan's medical necessity criteria); and failing to consult with your treatment provider.

5 How To Determine Your Type of Health Insurance Plan

The first step in enforcing your rights under the federal parity law is finding out whether the law applies to your health plan! You also need this information in order to enforce your rights under the New York State laws discussed in Section 6.

To find out what kind of plan you have, you can call the number on the back of your insurance card and ask, or you can use this tool. If you use this tool, you should still follow up with your health plan to make sure you have correctly determined your plan type. Once you know what kind of health plan you have, you can read Section 7 ("What To Do If Your Health Plan May Be Violating the Federal Parity Law").

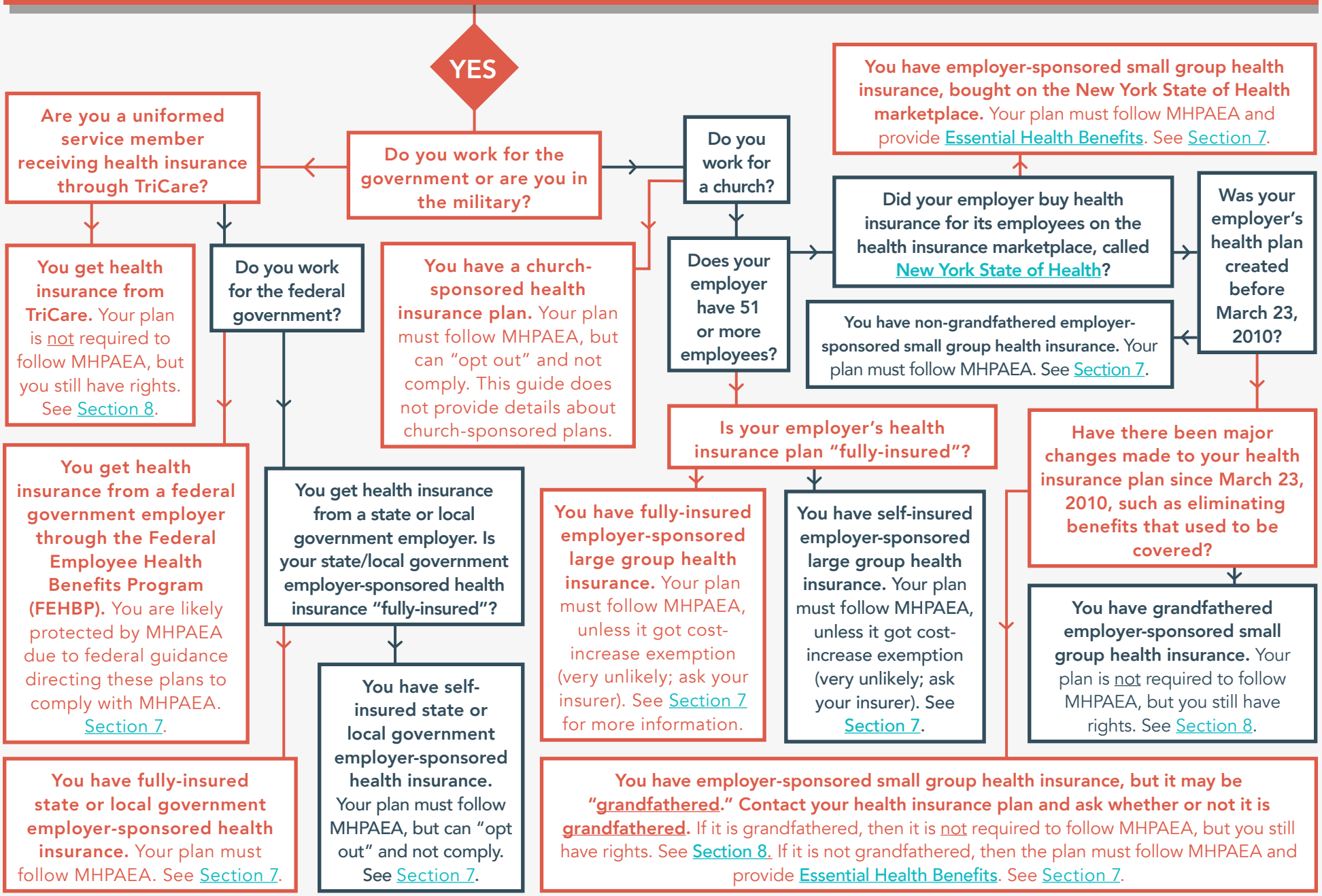
Note that retiree-only health plans are not included in this tool. (Retiree-only health plans are group health plans where fewer than two of the plan's beneficiaries are current employees.) If you have a retiree-only plan, your plan is not required to comply with the federal parity law. Go to Section 8 for more information about plans that are not covered by the federal parity law.

After learning what type of plan you have, find it in the Key on page 28. Each plan has a corresponding color, shape, and number you can use to follow your plan throughout Sections 6 and 7.

Do you receive health insurance from your employer?

including private employers, government employers, the military, etc.

Yes →
No →



Do you receive health insurance from your employer?

including private employers, government employers, the military, etc.

Yes →
No →

NO

You have an individual health insurance plan must follow MHPAEA and may be required to provide Essential Health Benefits. See Section 7.

Did you buy your own health insurance for yourself and/or your family?

Do you have health insurance through the Children's Health Insurance Program (CHIP), known in New York as Child Health Plus Plan (CHP)?

You have CHIP. Your plan must follow MHPAEA. See Section 7.

Do you have Medicaid?

Do you have a Medicaid Managed Care plan?

You have Medicaid Managed Care health insurance. Your plan must follow MHPAEA. See Section 7.

Do you have Medicare?

Do you have traditional, fee-for-service Medicaid?

Do you have both Medicare and Medicaid ("dual-eligible")?

You have Medicare. Your plan is not required to follow MHPAEA, but you still have rights. *See* Section 8.

Are any of your benefits administered by a managed care plan (for example, your behavioral health benefits)?

Is your Medicaid delivered by a Medicaid Managed Care plan?

You have traditional fee-for-service Medicaid with some Medicaid Managed Care benefits. Your plan must follow MHPAEA. See Section 7.

You have traditional fee-for-service Medicaid. Your plan is not required to follow MHPAEA, but you still have rights. See Section 8.

You have Medicare and traditional, fee-for-service Medicaid. Your plan is not required to follow the federal parity law, but you still have rights. See Section 8.

You have Medicare and Medicaid Managed Care. Your Medicaid Managed Care plan – but not your Medicare plan – must follow MHPAEA. See Section 7.

Health Plan Key

Health Plans In This Document

Find your plan type in the key and use its color, shape, and number to follow it through the next few sections of the guide to learn more about your rights.

1. **Individual Plan**
2. **Small Group Plan Bought on Marketplace**
3. **Small Group Plan Not Bought on Marketplace, Non-Grandfathered**
4. **Fully-Insured Large Group Plan**
5. **Self-Insured Large Group Plan, Non-Grandfathered**
6. **Self-Insured Large Group Plan, Grandfathered**
7. **Federal Government Employer Plan**
8. **State or Local Government Employer Plan, Fully-Insured**
9. **State or Local Government Employer Plan, Self-Insured**
10. **Medicaid Managed Care Plan**
11. **Child Health Plus Plan**

6 Additional Protections Under New York State Laws

New York State law provides additional protections for MH/SUD services, including a State parity law, for people with certain types of health plans. This section discusses several New York State laws that are especially relevant to people seeking insurance coverage of MH/SUD services, but it is not a comprehensive overview of New York State law. For information about other New York State laws, you may contact the State Department of Financial Services, the State Department of Health, or an attorney.

Please note that new laws to combat the opioid crisis passed in New York in June 2016. This Guide does not explain those new laws. For additional information, please visit www.lac.org.

The protections described in this section apply to following types of health plans:[53]

Plans Protected by Certain New York State Laws

- 1 — Individual Plan
- 4 — Fully-Insured Large Group Plan
- 3 — Small Group Plan Not Bought on Marketplace, Non-Grandfathered
- 8 — State or Local Government Employer Plan, Fully-Insured
- 9 — State or Local Government Employer Plan, Self-Insured

If you have one of the types of plans listed in the chart, New York State law provides the following additional protections:

1) Your health plan must cover both inpatient and outpatient diagnosis and treatment of substance use disorders, including detoxification and rehabilitation services, and must do so in compliance with the federal parity law.[54]

2) Family members of people receiving the inpatient and outpatient SUD services that plans are required by law to cover must be provided up to 20 outpatient visits per policy or calendar year.[55]

3) Your health plan must cover at least 30 days of inpatient mental health care and at least 20 days of outpatient mental health care.[56]

4) Your health plan is required to provide "broad based coverage for the diagnosis of mental, nervous or emotional disorders or ailments" that is at least equal to coverage provided for other health conditions.[57]

5) Your health plan must cover at least 30 days of inpatient mental health care and at least 20 days of outpatient mental health care.[58] Your health plan must provide coverage for adults and children with "biologically based mental illness"[59] and for children with "serious emotional disturbances"[60] that is comparable to the coverage it provides for other physician services and inpatient hospital care.[61]

6) Health plans that cover psychiatric or psychological services must reimburse for those services regardless of whether they are provided by a physician, psychiatrist, certified and registered psychologist, or licensed clinical social worker.[62]

7) If you submit a claim for inpatient SUD treatment at least 24 hours before being discharged from an inpatient admission, your health plan may not deny the claim on the basis of medical necessity or lack of prior authorization while the health plan's determination about whether to provide coverage is pending.[63]

8) Your plan is required to use LOCADTR 3.0 or another tool approved by the New York Office of Alcoholism and Substance Abuse Services (OASAS) when deciding what level of MH/SUD care is appropriate for you (for example, outpatient vs. inpatient care).[64]

9) Upon request, your plan must provide you with the clinical review criteria it used to make an adverse benefit determination, as well as the specific written clinical review criteria relating to a particular condition or disease.[65]

If you have another type of health insurance coverage, such as Medicaid, CHP, or a self-insured group plan, you are not protected by the New York State laws listed above, but you are likely protected by the federal parity law, the ACA, ERISA, and other federal and state laws.[66]

If you have a Medicaid Managed Care plan, your plan is required to use the LOCADTR 3.0 tool, developed by the New York Office of Alcoholism and Substance Abuse (OASAS), when determining which level of MH/SUD care is appropriate for you.[6]

7 What To Do If Your Health Insurance Plan May Be Violating The Federal Parity Law

When your health plan decides not to cover or pay for your MH/SUD care because it says the care is not medically necessary or is experimental or investigational, the plan's decision is referred to as an adverse benefit determination, and you have the right to challenge it. This is true no matter what type of health insurance plan you have, and even if your health plan is not covered by the federal parity law. Depending on what type of plan you have, you also may have the right to challenge decisions by your plan to not cover or pay for your MH/SUD care for other reasons. Your health care provider can also challenge a plan's decision on your behalf.

When your plan issues an adverse benefit determination, you can still do a number of things to try to get your MH/SUD services covered or paid for, and to try to get your plan to follow the federal parity law if it is not doing so:

A. Internal Appeal
B. External Appeal/Review
C. Grievance
D. Fair Hearing (Medicaid only)
E. Complaint to Government Agency
F. Lawsuit

Each of these 6 options is discussed in more detail below. Your options may vary depending on what type of health plan you have. The guide will note differences in available options.

Note that the entity reviewing your appeal, grievance, or complaint may not look at whether your health plan is violating the federal parity law unless you specifically raise the law. In addition, if you do not raise parity in your original appeal, grievance, or complaint, courts and other reviewing agencies may not be able to consider parity later on, if you want them to. Therefore, it is very important to specifically state in any appeal, grievance, or government complaint that you believe your plan is violating the federal parity law. See Section 12 for sample appeals and complaints.

It is also very important to keep track of all of your communications with your health plan, as well as all appeals, grievances, and complaints you file. You should:

- Keep a list of every time you communicate with your health plan or a government agency (whether by phone, email, or mail). On the list, write the date of the communication, the name of the person you spoke to, and what the person you spoke to said.

- Keep copies of all written communications with your health plan or government agencies, including: internal appeals, grievances, external appeals/reviews, and complaints. Keep copies of both what you send to them and what they send to you.

If you need help, Community Service Society's Community Health Advocates ("CHA") is New York State's designated Consumer Assistance Program under the Affordable Care Act. You can contact CHA for assistance with things like filing appeals by visiting www.communityhealthadvocates.org or calling CHA's toll-free hotline at 1-888-614-5400.

A. Internal Appeal

An internal appeal is a request for your health insurance plan to reconsider its denial of coverage or payment. (If you have a Medicaid or CHP plan, this may be referred to as a "utilization review appeal" or an "action appeal" rather than an "internal appeal.") Every type of health plan that is covered by the federal parity law also has the right to internal appeal (and so do most types of plans that are not covered by the federal parity law). Many types of plans also allow you to appoint a representative to file your internal appeal for you.[68]

No matter what type of health plan you have, you have the right to file an internal appeal when your plan denies you services or payment because it says they are not medically necessary or are experimental or investigational.[69] Most plans also allow you to file an internal appeal any time your plan denies services or payment for one of the following reasons:

- the benefit isn't offered under your plan;
- your medical problem began before you joined the plan;
- you received out-of-network services;
- you are no longer eligible to be enrolled in your plan; or
- your plan is revoking your coverage.[70]

However, if you have one of the plan types listed on the next page, your internal appeal rights are slightly different. **Find your plan on the next page to see if you have additional internal appeal rights:**

Additional Internal Appeal Rights

1 Individual Plan[71]

You have the right to an internal appeal in all of the circumstances listed on the previous page. Unless you have a grandfathered plan, you also have the right to an internal appeal regarding initial eligibility determinations.

10 Medicaid Managed Care Plan[72]

In addition to denials based on a determination that the service is not medically necessary or is experimental or investigational, you have the right to an internal appeal when your health plan…

- Denies or limits authorization of a service you requested, including type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as defined by the State;
- Fails to follow required appeals timeframes; or
- For a resident of a rural area with only one Medicaid Managed Care plan available, denies a Medicaid enrollee's request to exercise his or her right, in some circumstances, to obtain services outside the network.

11 Child Health Plus Plan[73]

In addition to denials based on a determination that the service is not medically necessary or is experimental or investigational, you have the right to an internal appeal regarding….

- Any delay, denial, reduction, suspension, or termination of health care services.

If your health plan denies a claim (a request for coverage or payment) submitted by you or your health care provider, the plan must notify you in writing and explain the reason for its denial. Remember, this is called an adverse benefit determination. When your health plan notifies you of its adverse benefit determination it will tell you what your appeal rights are, but you can also call the number on the back of your insurance or Medicaid card and ask how to file an internal appeal and how long you have to do so. Depending on what type of health plan you have, the law requires your plan to give you a certain amount of time to file your internal appeal. **Find your plan type on the next page to learn how long you have to file an internal appeal—though always double-check with your plan to confirm how much time you have.**[74]

Remember to always check with your plan to make sure you understand the appeal process, including any deadlines.

How Long You Have to FILE Internal Appeal

1 Individual Plan[75]

How long you have to file an internal appeal depends on what type of individual plan you have. If you did not buy your plan on the "New York State of Health" marketplace, *and* if your plan is grandfathered, your plan is required by New York State law to give you at least ***45 days*** to file an internal appeal. If you have any other type of individual plan, federal law requires that the plan give you at least ***180 days*** to file an internal appeal.

2 Small Group Plan Bought on Marketplace[76]

Federal law requires that the plan give you at least ***180 days*** to file an internal appeal.

3 Small Group Plan Not Bought on Marketplace, Non-Grandfathered[77]

Federal law requires that the plan give you at least ***180 days*** to file an internal appeal.

4 Fully-Insured Large Group Plan[78]

Federal law requires that the plan give you at least ***180 days*** to file an internal appeal.

5 Self-Insured Large Group Plan, Non-Grandfathered[79]

Federal law requires that the plan give you at least ***180 days*** to file an internal appeal.

6 Self-Insured Large Group Plan, Grandfathered[80]

Federal law requires that the plan give you at least ***180 days*** to file an internal appeal.

7 Federal Government Employer Plan[81]

Federal law requires that the plan give you at least ***6 months*** to file an internal appeal.

8 State or Local Government Employer Plan, Fully-Insured[82]

New York State law requires that the plan give you at least ***45 days*** to file an internal appeal.

9 State or Local Government Employer Plan, Self-Insured[83]

New York State law requires that the plan give you at least ***45 days*** to file an internal appeal.

10 Medicaid Managed Care Plan[84]

The contract that all Medicaid Managed Care plans in New York must sign with the State requires that the plan give you at least ***60 days*** to file an internal appeal.

11 Child Health Plus Plan[85]

New York State law requires that the plan give you at least ***45 days*** to file an internal appeal.

Remember to always check with your plan to make sure you understand the appeal process, including any deadlines.

After you file an internal appeal, your health plan will decide either to overturn its earlier denial of your claim, in which case it will cover the services you requested, or to uphold the original denial of your claim (this is called a *final* adverse benefit determination). **Find your plan type on the next page to learn how long your plan has to make this decision.**

How Long Your Plan Has to DECIDE Your Internal Appeal

1 Individual Plan[86]

If you have not yet received the service that the health plan denied coverage or payment for, the plan must complete the internal appeal within ***30 days***. If you have already received the service, the plan must complete the internal appeal within ***60 days***.

2 Small Group Plan Bought on Marketplace[87]

If you have not yet received the service that the health plan denied coverage or payment for, the plan must complete the internal appeal within ***30 days***. If you have already received the service, the plan must complete the internal appeal within ***60 days***.

3 Small Group Plan Not Bought on Marketplace, Non-Grandfathered[88]

If you have not yet received the service that the health plan denied coverage or payment for, the plan must complete the internal appeal within ***30 days***. If you have already received the service, the plan must complete the internal appeal within ***60 days***.

4 Fully-Insured Large Group Plan[89]

If you have not yet received the service that the health plan denied coverage or payment for, the plan must complete the internal appeal within ***30 days***. If you have already received the service, the plan must complete the internal appeal within ***60 days***.

5 Self-Insured Large Group Plan, Non-Grandfathered[90]

If you have not yet received the service that the health plan denied coverage or payment for, the plan must complete the internal appeal within ***30 days.*** If you have already received the service, the plan must complete the internal appeal within ***60 days.***

6 Self-Insured Large Group Plan, Grandfathered[91]

If you have not yet received the service that the health plan denied coverage or payment for, the plan must complete the internal appeal within ***30 days***. If you have already received the service, the plan must complete the internal appeal within ***60 days.***

Some plans allow for two levels of internal appeal. (To find out whether your plan has two levels, call the number on the back of your insurance card.) If your plan allows two internal appeals, it must provide you its decisions more quickly: within ***15 days*** for each appeal if you have not yet received the service, and within ***30 days*** for each appeal if you have already received the service.

7 Federal Government Employer Plan[92]

The plan must complete the internal appeal within ***30 days*** of receiving it.

8 State or Local Government Employer Plan, Fully-Insured[93]

The plan must complete the internal appeal within ***60 days*** of receiving all necessary information.

9 State or Local Government Employer Plan, Self-Insured[94]

The plan must complete the internal appeal within ***60 days*** of receiving all necessary information.

10 Medicaid Managed Care Plan[95]

The plan must complete the internal appeal as quickly as your health situation requires, and within ***30 days*** from when it receives all of the information necessary to complete your appeal. (This timeframe can be extended by up to ***14 days*** in certain circumstances.) Your plan is also required to give you a reasonable opportunity to present evidence and an opportunity to examine your case file (including medical records and any other records considered during the appeal process).

11 Child Health Plus Plan[96]

The plan must complete the internal appeal within ***60 days*** of receiving all necessary information.

Most plans also provide the right to an **expedited** internal appeal in certain circumstances. **Find your plan type below and on the following pages to learn whether, and when, you have the right to an expedited internal appeal**. Note that when filing an **expedited** internal appeal, you should make sure that your provider will be available to provide any additional information your plan might need during the short (expedited) time-frame, especially if the appeal will be decided during a weekend.

Expedited Internal Appeal Rights

1 Individual Plan[97]

You have the right to an *expedited* internal appeal when…

- You have an **urgent** health situation, meaning the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment for which you are making the claim. These expedited appeals must be decided no later than **72 hours** after your health plan receives your appeal.
- Your health care provider believes an immediate appeal is warranted. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are undergoing a course of continued treatment following discharge from an inpatient hospital admission. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are requesting inpatient SUD treatment. These expedited appeals must be decided no later than **24 hours** after your plan receives your appeal if the appeal is submitted at least **24 hours** before you are discharged from inpatient care. For additional protections related to expedited appeals for inpatient SUD treatment, *see* "Expedited Appeals for Inpatient SUD Treatment," on page 39.

2 Small Group Plan Bought on Marketplace[98]

You have the right to an *expedited* internal appeal when…

- You have an **urgent** health situation, meaning the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment for which you are making the claim. These expedited appeals must be decided no later than **72 hours** after your health plan receives your appeal.
- Your health care provider believes an immediate appeal is warranted. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are undergoing a course of continued treatment following discharge from an inpatient hospital admission. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are requesting inpatient SUD treatment. These expedited appeals must be decided no later than **24 hours** after your plan receives your appeal if the appeal is submitted at least **24 hours** before you are discharged from inpatient care. For additional protections related to expedited appeals for inpatient SUD treatment, *see* "Expedited Appeals for Inpatient SUD Treatment," on page 39.

CONTINUED ON NEXT PAGE

Expedited Internal Appeal Rights Continued

3 Small Group Plan Not Bought on Marketplace, Non-Grandfathered[99]

You have the right to an *expedited* internal appeal when…

- You have an **urgent** health situation, meaning the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment for which you are making the claim. These expedited appeals must be decided no later than **72 hours** after your health plan receives your appeal.
- Your health care provider believes an immediate appeal is warranted. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are undergoing a course of continued treatment following discharge from an inpatient hospital admission. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are requesting inpatient SUD treatment. These expedited appeals must be decided no later than **24 hours** after your plan receives your appeal if the appeal is submitted at least **24 hours** before you are discharged from inpatient care. For additional protections related to expedited appeals for inpatient SUD treatment, *see* "Expedited Appeals for Inpatient SUD Treatment," on page 39.

4 Fully-Insured Large Group Plan[100]

You have the right to an *expedited* internal appeal when…

- Your situation is **urgent**, meaning the timeline for the standard appeal process could seriously jeopardize your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment for which you are making the claim. These expedited appeals must be decided within **72 hours** after your plan receives your appeal.
- Your health care provider believes an immediate appeal is warranted. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are undergoing a course of continued treatment following discharge from an inpatient hospital admission. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are requesting inpatient SUD treatment. These expedited appeals must be decided no later than **24 hours** after your plan receives your appeal if the appeal is submitted at least **24 hours** before you are discharged from inpatient care. For additional protections related to expedited appeals for inpatient SUD treatment, *see* "Expedited Appeals for Inpatient SUD Treatment," on page 39.

5 Self-Insured Large Group Plan, Non-Grandfathered[101]

You have the right to an *expedited* internal appeal when…

- Your situation is **urgent**, meaning the timeline for the standard appeal process could seriously jeopardize your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment for which you are making the claim. These expedited appeals must be decided within **72 hours** after your plan receives your appeal.

6 Self-Insured Large Group Plan, Grandfathered[102]

You have the right to an *expedited* internal appeal when…

- Your situation is **urgent**, meaning the timeline for the standard appeal process could seriously jeopardize your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment for which you are making the claim. These expedited appeals must be decided within **72 hours** after your plan receives your appeal.

CONTINUED ON NEXT PAGE

Expedited Internal Appeal Rights Continued

7 Federal Government Employer Plan

Ask your plan what rights, if any, you have to an expedited internal appeal.

8 State or Local Government Employer Plan, Fully-Insured[103]

You have the right to an *expedited* internal appeal when…

- Your health care provider believes an immediate appeal is warranted. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are undergoing a course of continued treatment following discharge from an inpatient hospital admission. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are requesting inpatient SUD treatment. These expedited appeals must be decided no later than **24 hours** after your plan receives your appeal if the appeal is submitted at least **24 hours** before you are discharged from inpatient care. For additional protections related to expedited appeals for inpatient SUD treatment, *see* "Expedited Appeals for Inpatient SUD Treatment," on page 39.

9 State or Local Government Employer Plan, Self-Insured[104]

You have the right to an *expedited* internal appeal when…

- Your health care provider believes an immediate appeal is warranted. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are undergoing a course of continued treatment following discharge from an inpatient hospital admission. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are requesting inpatient SUD treatment. These expedited appeals must be decided no later than **24 hours** after your plan receives your appeal if the appeal is submitted at least **24 hours** before you are discharged from inpatient care. For additional protections related to expedited appeals for inpatient SUD treatment, *see* "Expedited Appeals for Inpatient SUD Treatment," on page 39.

10 Medicaid Managed Care Plan[105]

You have the right to an *expedited* internal appeal when…

- Your plan determines, or your provider indicates, that a delay would seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function;
- Your plan denied services you requested following an inpatient admission; or
- Your plan denied your request to continue, extend, or increase services it previously approved.

In all of these situations, the plan must decide your expedited internal appeal within **2 business days** of receiving all necessary information, and no later than **3 business days** after receiving your appeal.

If the plan denies your request for an *expedited* internal appeal, it must decide your internal appeal within the standard internal appeal timeframe.

REMEMBER: You can also request a fair hearing without going through the appeal process first.

11 Child Health Plus Plan[106]

You have the right to an *expedited* internal appeal when…

- The timeline for the standard appeal process would seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function. These expedited appeals must be decided within **72 hours**.
- Your health care provider believes an immediate appeal is warranted. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are undergoing a course of continued treatment following discharge from an inpatient hospital admission. These expedited appeals must be decided no later than **2 business days** after your plan receives your appeal.
- You are requesting inpatient SUD treatment. These expedited appeals must be decided no later than **24 hours** after your plan receives your appeal if the appeal is submitted at least **24 hours** before you are discharged from inpatient care. For additional protections related to expedited appeals for inpatient SUD treatment, *see* "Expedited Appeals for Inpatient SUD Treatment," on page 39.

Expedited Appeals for Inpatient SUD Treatment: If you have the type of plan that allows for special expedited appeals for inpatient SUD treatment, your plan must decide these expedited appeals no later than ***24 hours*** after your plan receives your appeal *if* the appeal is submitted at least 24 hours before you are discharged from inpatient care. You may also file an expedited external appeal at the same time you file an expedited internal appeal. If you file an expedited internal and external appeal within 24 hours of receiving an adverse benefit determination for inpatient SUD treatment, your plan is not allowed to deny your treatment on the basis of medical necessity or lack of prior authorization while this type of appeal is pending. If the external appeal agent ultimately upholds the plan's denial of inpatient SUD treatment, your plan is only allowed to deny the inpatient SUD services *from that date forward*—it cannot refuse to pay for the services you already received while the appeal was pending. ***But remember, this protection only applies when the appeal is filed within 24 hours of receiving the adverse benefit determination.***[107]

When your plan makes a decision about your internal appeal, it must notify you in writing. This notification must explain the reason for the plan's decision and provide you with information about any external appeal/review rights you have.[127] If you have a large or small group plan or an individual plan, and your plan upholds its adverse benefit determination on appeal, it must also provide you with the following: reference to the specific plan provisions on which the adverse benefit determination is based; free copies, upon request, of all documents, records, and other information relevant to your claim for benefits; and, if the adverse benefit determination was based on medical necessity or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances.[109]

If you have Medicaid, notification of the plan's decision on your internal appeal must include information about your right to a fair hearing.[110] (See Section 7-B for more information on external appeals/reviews and Section 7-D for more information about fair hearings.) Some plans are also required to provide you with additional information if you request it.[111] If you filed an **expedited** internal appeal, your plan may be permitted to notify you of its decision verbally, but then must follow with written notification.[112] If your expedited internal appeal is not successful, you can still use the standard internal and external appeals process.[113]

For most types of health plans, you can file an external appeal/review, including an **expedited** external appeal/review, at the same time that you file an **expedited** internal appeal. With most plan types you also have the right to skip internal appeal and go directly to external appeal/review if both you and your plan agree to do so.[114] Remember that, when filing **expedited** appeals, you should make sure that your provider will be available to provide any additional information your plan might need during the short (expedited) time-frame, especially if the appeals will be decided during a weekend. See Section 7-B for more information about external appeals/reviews.

Remember to save all documents and correspondence related to any internal appeals you file. See Section 12 for a sample internal appeal regarding possible violations of the federal parity law.

If you need help, Community Service Society's Community Health Advocates ("CHA") is New York State's designated Consumer Assistance Program under the Affordable Care Act. You can contact CHA for assistance with things like filing appeals by visiting www.communityhealthadvocates.org or calling CHA's toll-free hotline at 1-888-614-5400.

B. External Appeal

An external appeal/review is a review by an independent third party (not someone who works for the plan) of your health plan's denial (adverse benefit determination). All health plans that are required to follow the federal parity law must provide an external appeal/review process, with one exception: self-insured large group health plans that are grandfathered.[115] When you receive notification of an adverse benefit determination, it will include a description of your right to an external appeal/review (if you have one) and of the external appeal/review process.[116]

There are generally two circumstances in which you can file an external appeal/review:

(i) you filed an internal appeal and the plan upheld its earlier adverse benefit determination; or
(ii) you have an **urgent** health situation.[117]

(i) Internal Appeal, Adverse Benefit Determination Upheld

You may have the right to an external appeal/review if you file an internal appeal and your plan upholds its adverse benefit determination based on the plan's medical judgment. This includes adverse benefit determinations where the plan says the services you requested: are not medically necessary; do not meet the plan's requirements for appropriateness, health care setting, level of care, or effectiveness; are experimental or investigational; or are out-of-network and an alternate recommended treatment or provider is available in-network.[118] Final regulations implementing appeal rights under the ACA also make clear that most people have the right to request an external appeal/review of a plan's determination that it complies with the federal parity law's non-quantitative treatment limitation requirements.[119]

If you have one of the following types of plans, you have the right to an external appeal/review when the plan upholds its earlier denial after internal appeal:

Plans With External Appeal Rights After Denial Upheld

1. **Individual Plan**[120]
2. **Small Group Plan Bought on Marketplace**[121]
3. **Small Group Plan Not Bought on Marketplace, Non-Grandfathered**[122]
4. **Fully-Insured Large Group Plan**[123]
5. **Self-Insured Large Group Plan, Non-Grandfathered**[124]
7. **Federal Government Employer Plan**[125]
8. **State or Local Government Employer Plan, Fully-Insured**[126]
9. **State or Local Government Employer Plan, Self-Insured**[127]
10. **Medicaid Managed Care Plan**[128]
11. **Child Health Plus Plan**[129]

(ii) ***Urgent Health Situation***

If you have any of the plan types listed in Section (i) ("Internal Appeal, Adverse Benefit Determination Upheld") other than a federal government plan, you also have the right to request an **expedited** external appeal/review if you have an **urgent** health situation.[154] (If you have a federal government plan, you should check with your plan to find out whether you have the right to an expedited external appeal/review.)

For most types of plans, an **urgent** health situation means your attending physician has stated that a delay in providing the health care service would pose an imminent or serious threat to your health. If you have a self-insured large group plan (non-grandfathered), the definition of an **urgent** health situation is broader: it is any situation that would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or where you received emergency services and have not yet been discharged from the facility.[131]

If your situation is **urgent**, you can request an **expedited** external appeal/review after you file an internal appeal and receive a final adverse benefit determination, *or* you can request it at the same time you request an **expedited** internal appeal without waiting for your plan's decision about your internal appeal. You may also skip the internal appeal entirely and go directly to **expedited** external appeal/review if both you and your plan agree to do so. These expedited appeals generally must be decided within ***72 hours.***[132] If you are requesting an **expedited** external appeal/review, you must call the New York State Department of Financial Services (DFS) at (888) 990-3991 and let them know.[133]

Some types of health plans may allow you to request an external appeal/review in additional situations, like when your coverage is rescinded.[134] You can check with your health plan to find out whether there are other circumstances in which you can file an external appeal/review.

Most types of plans must give you at least ***4 months*** from the date you receive notice of the plan's final adverse benefit determination to file an external appeal/review (exceptions to this time frame are noted below). Health care providers filing external appeals/reviews on their own behalf, generally have only ***60 days*** from the final adverse benefit determination.[135] However, if you have a federal government employer, you have only ***90 days*** to ask that the U.S. Office of Personnel Management (OPM) review your plan's adverse benefit determination.[136]

Remember to always check with your plan to make sure you understand the appeal process, including any deadlines.

Some types of health plans are allowed to charge a fee for an external appeal/review, although the fee may not exceed $25 and must be waived if it will pose a hardship. If your health care provider is filing its own external appeal/review, the plan may not charge the provider more than $50. If you file multiple external appeals/reviews in the same year, your plan cannot charge you more than $75 total during the year for your appeals.[137] **The following types of plans may not charge you any fee when you file an external appeal/review (the external appeal/review is free):**

Plans That May Not Charge Fee For External Appeal/Review

5 **Self-Insured Large Group Plan, Non-Grandfathered**[138]

10 **Medicaid Managed Care Plan**

11 **Child Health Plus Plan**[139]

For most types of health plans in New York State, the New York Department of Financial Services (DFS) decides external appeals/reviews. DFS assigns an external appeal agent to each external appeal/review.[140] **However, DFS does not decide the following plan types' external appeals/reviews:**

External Appeals Not Decided by DFS

5 **Self-Insured Large Group Plan, Non-Grandfathered**[141]

Because self-insured large group plans in New York State do not participate in either the state or federal external appeal/review process, these health plans are required to contract with independent review organizations to handle their external appeals/reviews.

7 **Federal Government Employer Plan**[142]

If you file an internal appeal and your plan upholds its earlier denial of your claim, you can appeal the plan's decision to the U.S. Office of Personnel Management (OPM).

When deciding whether to overturn your plan's adverse benefit determination, the external appeal agent must consider the following information: your plan's clinical standards; any information that was provided about the patient; and the attending physician's recommendation.[143] **The external appeal agent also must consider the following factors depending on the basis for the plan's denial:**

- **Medical Necessity Denial**: If the external appeal agent is conducting an external appeal/review because your health plan said the service you requested or received was not medically necessary, the agent must overturn your plan's denial if the agent determines your plan did not act reasonably, with sound medical judgment, and in the patient's best interest. When reviewing medical necessity denials, external appeal agents must consider the following additional information: applicable and generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards, and associations.[144]

- **Experimental/Investigational Denial**: If the external appeal agent is conducting an external appeal/review because your health plan said the service you requested or received is experimental or investigational, the agent must overturn your plan's denial if the agent determines: the requested service is likely to be more beneficial than any standard treatment for the patient's condition or disease; the requested service is likely to benefit the patient; and the benefit of the requested service to the patient outweighs the service's risks. When reviewing experimental/investigational denials, external appeal agents must consider the following additional information:

the applicable medical and scientific evidence; any evidence presented by the patient, the patient's designee, or the patient's physician; the patient's medical record; and any other pertinent information.[145]

» **Out-of-Network Service Denial**: If the external appeal agent is conducting an external appeal/review because the service you requested or received is out-of-network, and your plan denied the service on the grounds that an alternate recommended treatment is available in-network, the agent must overturn the plan's denial if it determines: the out-of-network service is likely to be more clinically beneficial than the alternate recommended in-network service; and the risk of the out-of-network service would not be substantially greater than the risk of the in-network service. When reviewing out-of-network service denials, external appeal agents must consider the following additional information: the applicable medical and scientific evidence; the patient's medical record, and any other pertinent information that the out-of-network service is likely to be more beneficial and would not substantially increase risk to the patient.[146]

» **Out-of-Network Referral Denial**: If the external appeal agent is conducting an external appeal/review because your out-of-network referral was denied by your plan on the grounds that the plan has an in-network provider with appropriate training and experience to meet the patient's needs and is able to provide the requested service, the external appeal agent must overturn the plan's denial if the agent determines: the health plan does not have a provider with the appropriate training and experience to meet the patient's needs and who is able to provide the requested service; the out-of-network provider does have the appropriate training and experience to meet the patient's needs and is able to provide the requested service; and the out-of-network provider is likely to produce a more clinically beneficial outcome. When reviewing out-of-network referral denials, external appeal agents must consider the following additional information: the training and experience of both the requested out-of-network provider and the recommended in-network provider; the patient's medical record; and any other pertinent information.[147]

Note that if you have a self-insured (non-grandfathered) plan, the factors an external appeal agent must consider may be slightly different.[148] Similarly, if you have a federal government plan, the factors that OPM considers in deciding your external appeal may be different than the ones listed here.[149]

For most types of health plans, the external review agent must make a decision about your external appeal/review within ***30 days***, unless the external appeal/review is **expedited**.[150] This timeline is a bit longer if you have a self-insured large group plan (non-grandfathered) or a federal government plan. If you have a self-insured large group plan (non-grandfathered), the external review agent has to make a decision within ***45 days***.[151] If you have a federal government plan, OPM has ***90 days*** to make a decision.[152] Most **expedited** external appeals/reviews must be decided within ***72 hours***.[153] See Section 7-B-ii ("Urgent Health Situation") for more information about **expedited** external appeals/reviews.

After you file an external appeal/review, the external appeal agent will decide to either overturn the health plan's adverse

benefit determination, in which case the health plan will be required cover the services you requested, or it will uphold the health plan's earlier adverse benefit determination. You will be provided with a written notice of the decision, which must include the reasons for the determination. For most types of health plans, the notice of external appeal/review determination must also include the clinical rationale for the determination if the external appeal agent is upholding the plan's earlier adverse benefit determination. Your plan must accept the external appeal/review decision.[154]

Remember to save all documents and correspondence related to your external appeals/reviews. See Section 12 for a sample external appeal/review regarding possible violations of the federal parity law.

If you need help, Community Service Society's Community Health Advocates ("CHA") is New York State's designated Consumer Assistance Program under the Affordable Care Act. You can contact CHA for assistance with things like filing appeals by visiting www.communityhealthadvocates.org or calling CHA's toll-free hotline at 1-888-614-5400.

C. Grievance

Most types of health plans also are required to let you file a "grievance." While internal and external appeals can only be filed to challenge adverse benefit determinations based on certain grounds, such as medical necessity, you may file a grievance to challenge *any* decision or action taken by your health plan. For example, you could file a grievance if the plan never sent you information you requested and were entitled to, or if you had a bad experience with one of the plan's doctors. **You have the right to file a grievance if you have one of the plan types listed below.** If your plan is not on this list, contact your plan to find out whether you can file a grievance.

Plans With Grievance Rights

1. **Individual Plan**[155]
2. **Small Group Plan Bought on Marketplace**[156]
3. **Small Group Plan Not Bought on Marketplace, Non-Grandfathered**[157]
4. **Fully-Insured Large Group Plan**[158]
9. **State or Local Government Employer Plan, Self-Insured**[159]
10. **Medicaid Managed Care Plan**[160]
11. **Child Health Plus Plan**[161]

For all of these plans *except* Medicaid Managed Care, the following deadlines apply: you have ***180 days*** from the date you receive an adverse benefit determination to file a grievance. Depending on whether you have already received the service at issue, your health plan has ***between 15 and 60 days*** to make a decision on the grievance. If the grievance is **urgent**, meaning a delay would significantly increase the risk to your health, then your plan must make a decision about the grievance within ***48 hours***. If your grievance is not successful, you have the right to appeal the health plan's decision.[162]

If you have Medicaid Managed Care, your plan must explain its grievance procedure in your Member Handbook and any time it denies access to a referral or determines that a requested benefit is not covered. When the plan provides you with the notice explaining its grievance procedure, it must explain the process for filing a grievance, how long the plan has to make a decision, and your right to designate a representative to file a grievance on your behalf.[163]

Remember to always check with your plan to make sure you understand the grievance process, including any deadlines. Also remember to save all documents and correspondence related to any grievances you file.

If you need help, Community Service Society's Community Health Advocates ("CHA") is New York State's designated Consumer Assistance Program under the Affordable Care Act. You can contact CHA for assistance with things like filing appeals and grievances by visiting www.communityhealthadvocates.org or calling CHA's toll-free hotline at 1-888-614-5400.

D. Fair Hearing—Medicaid *Only*

If you are enrolled in a Medicaid Managed Care ("MMC") plan, you have the right to a "fair hearing" and appeals under federal and New York State law.[164] Fair hearings are designed to be easier to navigate than traditional appeals processes, and can be a good option for people who find the appeals process confusing. Importantly, you also have the right in many cases to continue receiving services or benefits that have been denied by your health plan while you wait for a decision from your fair hearing. This is known as "aid continuing."[165] Fair hearings are one of the most important rights for people with Medicaid. Although all people with Medicaid have the right to a fair hearing, this section focuses on Medicaid Managed Care.

You are not required to complete internal appeals and external appeals/reviews before requesting a fair hearing. If you request a fair hearing, any decision made at that hearing will trump decisions made on your internal and external appeals.

A fair hearing is an opportunity for you to have an Administrative Law Judge review a decision made by your Medicaid Managed Care plan or a state agency—such as a decision to deny you benefits—and to decide whether your plan or the agency made a mistake. Federal law requires New York State to offer you the opportunity for a fair hearing any time your claim for benefits is denied or not acted upon with reasonable promptness.[166]

You can request a fair hearing when:

- Your claim for services is denied or not acted upon with reasonable promptness;
- Your Medicaid eligibility is terminated, suspended, or reduced;

- Your Medicaid covered services are delayed, suspended, reduced, or terminated (e.g., on medical necessity grounds);
- Coverage or payment for services is denied; or
- Your plan or the State takes certain actions related to your nursing facility care.[167]

If you want a fair hearing, you must request it within ***60 days*** of receiving notice of the determination, action, or failure to act about which you are complaining.[168] You have the right to be represented by an attorney or other representative, but you are not required to have an attorney or representative, and many people do not.[169] (See "If You Need Help" section, below.)

Note that the judge deciding your fair hearing may not consider whether your health plan is violating the federal parity law unless you specifically raise that law. In addition, if you do not raise parity in your fair hearing, courts and other reviewing agencies may not be able to consider parity later on. Therefore, it is very important to specifically state in any fair hearing pertaining to MH/SUD benefits that you believe your plan is violating the federal parity law.

A fair hearing can also give you access to information that can help you challenge your health plan's denial and clarify whether your plan is violating the federal parity law. For example, you have the right to examine your case record and all documents and records that will be submitted into evidence at the fair hearing.[198]

If you request a fair hearing, the hearing must be held at a reasonable time, date, and place, and you must receive adequate written notice of where and when the hearing will be held. You may receive priority in scheduling your fair hearing and receiving a decision from the judge if you have an **urgent** need for medical care.[172] Otherwise, the state has ***90 days*** after your fair hearing to issue a written decision. If the fair hearing decision is not in your favor, you will also receive notice of your right to ask a state court judge to review the decision.[173] The fair hearing decision is binding, and will take precedence over decisions made in response to any appeals and/or grievances you have filed.

People receiving Medicaid often have the very important **right to continue receiving denied Medicaid services** until a fair hearing decision has been issued. This is known as "aid continuing." To receive "aid continuing," you must request it quickly after receiving notice that your claim is being denied or your benefits discontinued—usually within ***10 days***.[171] When denying your claim, your plan is required to notify you of your right to "aid continuing" and what you need to do to request it. As always, make sure to pay close attention to deadlines.

You can request a fair hearing through the New York Office of Temporary and Disability Assistance ("OTDA") by online form, telephone, mail, fax, or in person. For more information on how to request a fair hearing, visit the OTDA website or call (800) 342-3334.

If you need help, Community Service Society's Community Health Advocates ("CHA") is New York State's designated Consumer Assistance Program under the Affordable Care Act. You can contact CHA for assistance with fair hearings by visiting

www.communityhealthadvocates.org or calling CHA's toll-free hotline at (888) 614-5400. You can also contact the Legal Aid Society's Health Law Unit for assistance, including to ask for an attorney to represent you at your fair hearing. If you live in New York City, you can reach the Health Law Unit at (212) 577-3575. If you live somewhere else in New York State, you can reach the Health Law Unit at (888) 500-2455.

E. Complaint to Government Agency

If you think your plan may be violating the federal parity law, you should file complaints with the government agencies that are tasked with enforcing that law, meaning that Congress specifically put them in charge of enforcing it. Filing these complaints is one of the most effective ways to make these agencies aware of health plans' broader policies and practices that may violate parity. By filing these complaints, you can help improve enforcement of the federal parity law overall.

Although not tasked by Congress with enforcing the federal parity law, the New York State Attorney General's (AG) Health Care Bureau has been leading the nation in parity enforcement. Therefore, if you think your plan may be violating the federal parity law—or any other law—you also should complain to the New York AG.

Each of these options is explained in more detail below.

(i) Agencies Tasked with Enforcement

The federal government agencies tasked with enforcing the federal parity law have delegated primary enforcement authority to the states. This means that you generally should file a complaint with the state government before filing a complaint with the federal government. (Note that if you have a federal government plan, there are no government agencies specifically tasked with enforcing your parity rights. If you have already gone through your internal and external appeals, you can complain to OPM or file a lawsuit (see Section 7-F.)

(a) *State Government Agencies*

The two state government agencies in charge of enforcing the federal parity law in New York State are the New York State Department of Financial Services (DFS) and the New York State Department of Health (DOH). **Find your plan in the chart below to learn which state government agency to direct your complaint to**. (If your plan is not listed in the chart below, you should skip complaining to a state government agency and go directly to the appropriate federal government agency. See Section (b) for more information.)

State Government Agencies	
Department of Financial Services	**Department of Health**
1 Individual Plan	10 Medicaid Managed Care Plan
2 Small Group Plan Bought on Marketplace	11 Child Health Plus Plan
3 Small Group Plan Not Bought on Marketplace, Non-Grandfathered	
4 Fully-Insured Large Group Plan	
8 State or Local Government Employer Plan, Fully-Insured	

Complaints to DFS:

Complaints to DFS can be filed by both patients and providers. When providers file complaints they are not limited to complaining about just one patient's individual situation. Rather, providers can complain to DFS about policies or patterns they are seeing from specific health plans that may violate the federal parity law. Therefore, complaints to DFS are an opportunity to resolve parity violations on both individual and systemic levels.

To file a complaint with DFS, you can use the online complaint form or contact the Consumer Assistance Unit at (800) 342-3736. You are not required to complete either the internal or external appeals process before filing a complaint with DFS, although DFS encourages patients and providers to try to work things out with the plan before filing a complaint. There is no deadline for filing this type of complaint with DFS. Once you submit the complaint, DFS will investigate and provide you with written notice of its conclusions.[174]

When complaining to DFS of a potential parity violation, be sure to:

- Specifically mention the Mental Health Parity and Addiction Equity Act of 2008, and your concern that your plan is violating that law; and
- Ask DFS for to provide you with written conclusions from its investigation.

Remember to save all documents and correspondence related to any complaints you file. See Section 12 for a sample complaint regarding possible violations of the federal parity law.

Complaints to DOH:

Complaints to DOH can be filed by both patients and providers.

To file a complaint with DOH, you can call 1-800-206-8125 or email managedcarecomplaint@health.ny.gov. If you would like your provider or another representative to file a complaint on your behalf, you will need to sign a release form allowing the DOH and your provider or representative to discuss your situation. You are not required to complete either the appeals or fair hearing process before filing a complaint with DOH, although DOH encourages patients and providers to try to work things out with the plan before filing a complaint. There is no deadline for filing this type of complaint with DOH. Once you submit the complaint, DOH will investigate and notify you of its conclusions.[175]

When complaining of a potential parity violation to DOH, be sure to:

- Specifically mention the Mental Health Parity and Addiction Equity Act of 2008, and your concern that your plan is violating that law; and
- Ask DOH for to provide you with its conclusions from its investigation in writing.

Remember to save all documents and correspondence related to any complaints you file. See Section 12 for a sample complaint regarding possible violations of the federal parity law.

(b) ***Federal Government Agencies***

The federal government agencies in charge of enforcing the federal parity law are the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL), and the U.S. Department of Treasury (Treasury).

Find your plan in the chart on the right to learn which federal government agency to direct your complaint to.

Complaints to HHS:

HHS will enforce the federal parity law if State government agencies are not "substantially enforcing" the law. If you have filed a complaint with a State government agency and have not received a satisfactory response, you may complain to HHS. You can file a complaint with HHS either by email, at phig@cms.hhs.gov, or by phone, at (877) 267-2323.

Remember to save all documents and correspondence related to any complaints you file. See Section 12 for a sample complaint regarding possible violations of the federal parity law.

Complaints to DOL:

You may file a complaint with DOL either online, at www.askebsa.dol.gov, or by calling (866) 444-3272. You also have the option of complaining to the Treasury's Internal Revenue Service ("IRS") by calling (202) 317-5500. There is no need to complain to both agencies; just choose one, and the agencies will coordinate between themselves.

Federal Government Agencies	
Department of Health and Human Services	**Department of Labor**
1 **Individual Plan**	5 **Self-Insured Large Group Plan, Non-Grandfathered***
2 **Small Group Plan Bought on Marketplace**	6 **Self-Insured Large Group Plan, Grandfathered***
3 **Small Group Plan Not Bought on Marketplace, Non-Grandfathered**	9 **State or Local Government Employer Plan, Self-Insured***
4 **Fully-Insured Large Group Plan**	
8 **State or Local Government Employer Plan, Fully-Insured**	
10 **Medicaid Managed Care Plan**	
11 **Child Health Plus Plan**	* These plans can also complain to the Treasury.

Remember to save all documents and correspondence related to any complaints you file. See Section 12 for a sample complaint regarding possible violations of the federal parity law.

(ii) ***New York State Attorney General***

If you think your health insurance plan is violating the federal parity law, or other laws such as the ACA and New York State Insurance Law, you can also complain to the AG's Health Care Bureau, which has been leading the nation in enforcing the federal parity law. Since 2014, the AG has settled cases against five New York health insurance plans for violating the federal parity law and, in some cases, the ACA and New York State law.

The AG has settled cases against the following health plans for parity violations: Cigna, MVP Health Care, Emblem Health, ValueOptions/Beacon Health Options, and Excellus Health Plan. Under settlements with the AG, these plans are already required to take corrective actions to remedy policies and practices that violated the law. Summaries of the AG's settlements, as well as copies of the settlements themselves, are available on the Legal Action Center website, here: lac.org/resources/substance-use-resources/parity-health-care-access-resources/new-york-attorney-general-parity-enforcement/.

If you think your health plan is violating the federal parity law and/or other laws, you may complain to the AG's Health Care Bureau at 1-800-428-9071.

iii. ***New York State Office of Alcoholism and Substance Abuse Services***

You may also contact the New York State Office of Alcoholism and Substance Abuse Services (OASAS) if you think your health plan is violating the federal parity law or other laws, such as the ACA and New York State Insurance Law. You may email OASAS at picm@oasas.ny.gov for assistance.

F. Lawsuit

If your appeals and complaints are unsuccessful, and you think your plan is violating the federal parity law, you may want to consider filing a lawsuit. There have been a number of lawsuits filed against health insurance plans accused of violating the federal parity law, including one filed in New York by the New York State Psychiatric Association against UnitedHealth.[176] If you are interested in filing a lawsuit, you should contact an attorney with expertise representing individuals denied health insurance coverage. If you need a referral, you may contact the New York State Bar Association at (800) 342-3661, or the New York City Bar Association at (212) 626-7373.

8 Plans That Are Not Covered by the Federal Parity Law

If you have a plan that is not covered by the federal parity law, do not despair! You are still protected by other laws and should fight for insurance coverage of your mental health or substance use disorder care. Depending on what type of plan you have, you may be protected by: the New York State parity law and other state laws (see Section 6); the Affordable Care Act ("ACA"); the Employee Retirement and Income Security Act ("ERISA"); and more.

To recap, the following types of health plans are *not* protected by the federal parity law:

- Grandfathered small group health plans;
- Traditional fee-for-service Medicaid (this type of Medicaid will become increasingly rare in New York State after 2015-2016);
- Medicare;
- Tricare; and
- Retiree-only plans.

Remember, however, that although TriCare plans are not required to comply with the federal parity law, the U.S. Department of Defense has proposed regulations to align TriCare plans with the requirements of the federal parity law. If these regulations are finalized, TriCare plans will have greater parity between MH/SUD and other medical/surgical benefits.[177]

In addition, some types of plans can opt out of complying with the federal parity law, although as of this writing we are not aware of any plans in New York State that have done so:

- Self-insured state and local government plans;
- Church-sponsored plans; and
- Plans that have successfully applied for a cost increase exemption.

If your plan is not required to comply with the federal parity law, you can still file appeals and complain to government agencies when your health plan will not cover your MH/SUD care. When you receive a notice that services are being denied, the notice should explain what your appeal rights are and who to contact for more information. You can also contact government agencies, such as the New York State Department of Financial Services, the New York State Department of Health, and the New York State Attorney General's Health Care Bureau with questions and concerns.

9 Glossary

Action: For people with Medicaid Managed Care plans, an action is any of the following: a denial or limited authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the managed care plan to follow required appeals timeframes; or, for a resident of a rural area with only one Medicaid Managed Care plan available, the denial of a Medicaid enrollee's request to exercise his or her right, in some circumstances, to obtain services outside the network.[178]

Adverse Benefit Determination: Adverse benefit determination means slightly different things depending on what type of plan you have. For large and small group plans and individual plans, an adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.[179] For some plans, an adverse benefit determination also includes any rescission of coverage.[180] With regard to individual health plans, an adverse benefit determination also includes any decision to deny coverage in an initial eligibility determination.[181] Medicaid plans use the term "action" rather than "adverse benefit determination." See the definition of "action" above.

Aid Continuing: For people with Medicaid, the right to continue receiving services or benefits that have been denied by their health plan until an appeal or fair hearing decision about those services is issued. This can also be called "aid paid pending" or "continued benefits."[182]

Aggregate Lifetime Limit: A dollar limitation on the total amount that may be paid by a plan toward an individual's benefits under the plan.[183]

Annual Limit: A dollar limitation on the amount that may be paid by a plan toward an individual's benefits in a 12-month period.[184]

Appeal: A request that your health plan review or reconsider its denial of coverage or payment.[185]

Claim: A request for coverage. A patient or health care provider will usually file a claim to be reimbursed for the costs of treatment or services.[186]

Classification: Under the federal parity law, all of a health insurance plan's benefits—mental health, substance use disorder, and medical/surgical—must be placed into one of six classifications: (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.[187] For CHIP and Medicaid plans that are covered by the federal parity law, all of a plan's benefits must be placed into one of four classifications: (1) inpatient; (2) outpatient; (3) emergency care; and (4) prescription drugs.[188] Plans may also choose to create two kinds of sub-classifications. See the definition of sub-classification for more information.

Co-Insurance: A percentage of the cost of a health care service that you pay, after you have paid any deductible.[189]

Co-Payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.[190]

Concurrent Review: When a health insurance plan reviews health care as it is provided to determine whether it is medically necessary (this is a type of utilization review).[191]

Cumulative Financial Requirements: Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts. Examples include deductibles and out-of-pocket maximums.[192]

Cumulative Quantitative Treatment Limitations: Treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.[193]

Deductible: When a patient is responsible for health care costs up to a specified dollar amount. After that dollar amount (the deductible) has been paid, the health insurance plan will begin to pay for health care costs.[194] For example, a patient may have to pay all of the first $500 of her health costs in a given year; once she has spent that much on health care, the health insurer starts paying for new costs she incurs. Note that, under the ACA, patients do not have to pay toward their deductibles for preventative care, like yearly physical exams.

Expedited Appeal: An appeal that gets decided more quickly by the reviewer, generally because the patient's health needs are urgent.[195]

External Appeal/External Review: A review, conducted by an independent third party (not someone who works for the health plan) of a plan's decision to deny coverage or payment. If the plan upholds its earlier adverse benefit determination after an internal appeal, an external appeal/review may be requested, depending on the grounds for the denial and what type of

plan the patient has. In urgent situations, an external appeal/review may be requested even if the internal appeal process is not yet completed. An external appeal/review either upholds or overturns the plan's adverse benefit determination. The plan must accept this decision.[196]

Fail First or Step Therapy Policies: A health plan's requirement that a lower-cost therapy be shown to be ineffective before a higher-cost therapy will be approved.[197]

Fair Hearing: An opportunity for you to have an Administrative Law Judge review a decision made by your Medicaid Managed Care plan or a state agency—such as a decision to deny you benefits—and to decide whether to overturn your plan's decision. Federal law requires New York State to offer you the opportunity for a fair hearing any time your claim for benefits is denied or not acted upon with reasonable promptness.[198]

Fee for Service: A health care delivery system where providers are paid for each service (like an office visit, test, or procedure).[199]

Financial Requirements: Includes deductibles, co-payments, co-insurance, and out-of-pocket expenses; does not include annual limits and aggregate lifetime limits.[200]

Fully-Insured Plan (also known as fully-funded): Health insurance plans provided by employers to their employees, where the employer buys a health plan for its employees from an insurance company, and the insurance company (not the employer) pays the costs of the employees' health care claims. If you get your health insurance from a small or mid-sized employer, it is likely that your plan is fully-insured.

Grandfathered: Small employer and individual market plans that were in existence before March 23, 2010 and that have not been changed since then in ways that substantially cut benefits or increase costs for consumers. For example, a plan may lose its grandfathered status by increasing the coinsurance amount for inpatient surgery from 20 to 25 percent, or by eliminating benefits for counseling for a mental health condition which were previously covered.[201]

Grievance: A complaint to a health plan to express dissatisfaction with something the plan has done does other than an adverse benefit determination or action.[202]

Health Insurance Marketplace/Exchange: Created by the Affordable Care Act (ACA) as a place where individuals can buy health insurance if they do not receive it from an employer, Medicaid, Medicare, CHIP, or another source. Health plans sold on the marketplace must cover certain "essential health benefits," with include MH and SUD benefits. New York's health insurance marketplace is called New York State of Health. Small employers (with 50 or fewer employees) can also buy health insurance for their employees on the health insurance marketplace. You can learn more about these marketplaces at www.healthcare.gov and www.nystateofhealth.ny.gov.

Internal Appeal: A request for your health insurer or plan to review a decision or grievance again.[203]

Large Group Plan: Under the federal parity law, a large group plan is one provided by an employer with 51 or more employees.[204]

Level (of a type of financial requirement or treatment limitation): The magnitude of a type of financial requirement or treatment

limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include $15 and $20; different levels of a deductible include $250 and $500; different levels of an episode limit include 21 inpatient days per episode or 30 inpatient days per episode.[205]

Lifetime Limit: A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.[206]

Medical Necessity Criteria: A variety of factors that health plans use to determine whether they will pay for a claim. The American Medical Association and the American Psychiatric Association define "medical necessity" as "services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider." Many health plans use this definition or a similar one to decide whether services are medically necessary.[207] See also Medically Necessary.

Medical or Surgical Benefits: Means benefits with respect to medical or surgical services, as defined under the terms of the plan or, for Medicaid and CHIP, by the State; does not include MH or SUD benefits.[208] The health plan's or State's decision to define a condition as a medical/surgical condition (or not a medical/surgical condition) must be consistent with generally recognized independent standards of current medical practice (such as the International Classification of Diseases (ICD), or state guidelines).[209]

Medically Necessary: Generally, health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.[210] The exact meaning of medically necessary varies among different types of plans. See also Medical Necessity Criteria.

Mental Health Benefits: Means benefits with respect to services for mental health conditions as defined under the terms of the plan or by the State and in accordance with applicable Federal and State law.[211] The health plan's decision to define a condition as a mental health condition (or not a mental health condition) must be consistent with generally recognized independent standards of current medical practice (such as the DSM, ICD, or state guidelines).[212]

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.[213]

Non-Grandfathered: Plans that are not grandfathered.

Non-Quantitative Treatment Limitations (NQTLs): Treatment limitations that are not expressed numerically but that otherwise limit the scope or duration of treatment. Examples of NQTLs include: medical management standards (like medical necessity criteria); formulary design for prescription drugs; network tier design (for plans that have multiple network tiers); standards for provider admission to participate in-network, including reimbursement rates; methods for determining usual, customary, and reasonable charges for a service; fail-first or step-therapy policies; exclusions based on failure to complete a course of

treatment; and restrictions based on geographic location, facility type, or provider specialty.[214]

Out-of-Pocket Maximum: A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs (excluding any amount they pay toward premiums).[215]

Predominant: A financial requirement or treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit or requirement.[216] The predominant level of a financial requirement or quantitative treatment limitation is the one that applies to more than one-half of the medical/surgical benefits in a classification that are subject to that financial requirement or quantitative treatment limitation.[217] (For non-quantitative treatment limitations (NQTLs), there is no mathematical formula for determining what is predominant.[218] Instead, the federal parity law says plans may not impose an NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying to MH/SUD benefits are comparable to, and applied no more stringently than, the ones used in applying the NQTL to medical/surgical benefits in the classification.)[219] Note that the final regulations implementing MHPAEA also provide guidance on how to determine the predominant level of financial requirement or treatment limitation if no one level applies to more than one-half of the medical/surgical benefits in a classification.[220]

Quantitative Treatment Limitations: Treatment limitations that are expressed numerically, such as limits on the number of days or visits or limits on the frequency of treatment.[221]

Rescission: A cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission. A cancellation or discontinuance of coverage is not a rescission if it has only a prospective effect or if it is effective retroactively only because of a failure to timely pay required premiums or contributions towards the cost of coverage.[222]

Self-Insured Plan (also known as self-funded or employer-funded): Health insurance plans provided by employers, where the employer pays directly for its employees' health care claims. Usually, employers with self-insured plans contract with a health insurer to administer the plan's benefits, even though the employer—not the insurer—actually pays for the health care used by its employees. Employees with self-insured health plans usually still receive a health insurance card with the name of an insurance company on it (this is the company administering the benefits). Generally the only way an employee can tell if her health plan is self-insured is to ask her employer or the insurance company that administers her benefits. If you get your health insurance from a very large employer, it is likely that your plan is self-insured.

Small Group Plan: Under the federal parity law, a small group plan is one provided by an employer with 50 or fewer employees.[223]

Sub-Classification: Plans are required by the federal parity law to place all benefits into one of six classifications (or, in the case of Medicaid and CHIP, one of four classifications). Plans are also permitted to create up to two kinds of sub-classifications. All plans covered by the federal parity law (private, Medicaid, and CHIP) may create a sub-classification separating office visits from all other outpatient services. Office visits would include, for

example, physician visits, while other outpatient services would include things like outpatient surgery, facility charges for day treatment centers, and laboratory charges.[224] Private plans (but not Medicaid and CHIP) are also permitted to make a second kind of sub-classification by creating multiple tiers of in-network providers. For example, a plan could have an in-network tier of "preferred providers," who are the least expensive, and an in-network tier of "participating providers," who are more expensive. If a plan divides its in-network providers into multiple tiers, these tiers are considered sub-classifications.[225]

Substance Use Disorder Benefits: Means benefits with respect to services for substance use disorders, as defined under the terms of the plan or by the State and in accordance with applicable Federal and State law.[226] The health plan's decision to define a disorder as a substance use disorder (or not a substance use disorder) must be consistent with generally recognized independent standards of current medical practice (such as the DSM, ICD, or state guidelines).[227]

Substantially All: At least two-thirds of all medical/surgical benefits in a classification of benefits.[228]

Treatment Limitation: Includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Does *not* include a permanent exclusion of all benefits for a particular condition or disorder (for example, excluding from the plan's coverage every type of treatment for the disorder of schizophrenia).[229] Treatment limitations include both Quantitative Treatment Limitations, which are expressed numerically (such as 50 outpatient visits per year) and Non-Quantitative Treatment Limitations (NQTLs), which otherwise limit the scope or duration of treatment.[230]

Type: (of financial requirement or treatment limitation): Means the nature of the financial requirement or treatment limitation. For example, different types of financial requirements include deductibles, co-payments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual limits, episode limits, and lifetime day and visit limits. For examples of different types of non-quantitative treatment limitations (NQTLs), see the definition above.[231]

Utilization Review: A health plan's review to determine whether health care services are medically necessary.[232]

10 Appendix: Other Rights

While the federal parity law is the focus of this guide, you have rights under a variety of state and federal laws not discussed in detail here. However, this guide briefly notes some additional legal protections you may have, depending on your type of health plan. You may want to raise these other laws in appeals, grievances, and complaints. Find your plan on the next page to learn about some of the additional protections. Note that this list is *not* exhaustive.

Other Rights

1 Individual Plan

You are protected by the New York State laws described in Section 6. Depending on what type of individual plan you have, you may also be protected by the ACA.

» Unless you have a grandfathered individual plan, your plan is required by the ACA to offer Essential Health Benefits, which include MH and SUD benefits. (Note, all plans sold on the New York State of Health marketplace are non-grandfathered, and so are most other individual plans.)

2 Small Group Plan Bought on Marketplace

You are protected by the New York State laws described in Section 6, as well as federal laws like the ACA and ERISA.

» ERISA regulations require health plans covered by ERISA to follow their own written rules.

» The ACA requires this type of plan to offer Essential Health Benefits, which include MH and SUD benefits.

» The ACA forbids this type of plan from designing or managing its essential benefits package in a way that limits coverage for people with disabilities, including people with MH/SUD.

» The ACA requires this type of plan's benefits to address the health care needs of diverse segments of the population, including people with disabilities such as MH/SUD.

3 Small Group Plan Not Bought on Marketplace, Non-Grandfathered

You are protected by the New York State laws described in Section 6, as well as federal laws like the ACA and ERISA.

» The ACA requires this type of plan to offer Essential Health Benefits, which include MH and SUD benefits.

4 Fully-Insured Large Group Plan

You are protected by the New York State laws described in Section 6, as well as federal laws like the ACA and ERISA.

» ERISA regulations require health plans covered by ERISA to follow their own written rules.

5 Self-Insured Large Group Plan, Non-Grandfathered

You are protected by ERISA and potentially the ACA.

» ERISA regulations require health plans covered by ERISA to follow their own written rules.

6 Self-Insured Large Group Plan, Grandfathered

You are protected by ERISA.

» ERISA regulations require health plans covered by ERISA to follow their own written rules.

7 Federal Government Employer Plan

You can ask the U.S. Office of Personnel Management what additional rights you may have.

8 State or Local Government Employer Plan, Fully-Insured

You are protected by the New York State laws described in Section 6.

10 Medicaid Managed Care Plan

You are protected by state and federal law.

» You have the right to a fair hearing and aid continuing. *See* Section 7-D for more information.

» Your plan is required to use LOCADTR 3.0, developed by the New York Office of Alcoholism and Substance Abuse Services, to make level of care determinations for SUD services.

» Your plan must cover inpatient and outpatient MH and SUD services.

» Your plan is required by state law (in addition to the federal parity law) to provide you with an adequate network. *See, e.g.*, N.Y. Soc. Serv. L. § 364-j(2)(c)(i).

» Your plan must use a broader definition of "medical necessity" when deciding whether to cover services for you. For Medicaid Managed Care plans, a service is medically necessary if a patient needs it to prevent, diagnose, correct or cure conditions that: cause him/her suffering, endanger his/her life, result in illness or infirmity, interfere with his/her capacity for normal activity, or threaten a significant disability. *See* N.Y. Soc. Serv. L. § 365-a(2); *see also* CHA Advocates Guide p. 136.

11 Endnotes

1. *See* SAMHSA, Behavioral Health Trends: Results from the 2014 National Survey on Drug Use and Health (Sept. 2015), http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm; SAMHSA, Receipt of Services for Behavioral Health Problems: Results from the National Survey on Drug Use and Health (Sept. 2015), http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf; Megan Thielking, "Drug Use Disorder Hits 1 in 10 US Adults," Stat (Nov. 18, 2105), http://www.statnews.com/2015/11/18/drug-use-disorder-nih-heroin; Centers for Disease Control & Prevention, Morbidity & Mortality Weekly Report (Dec. 18, 2015), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm64e1218a1.htm?s_cid=mm64e1218a1_w.
2. *See* SAMHSA, Receipt of Services for Behavioral Health Problems: Results from the National Survey on Drug Use and Health (Sept. 2015), http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf.
3. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3881 (2008).
4. Throughout this guide, the terms "health insurance plans," "health plans," "plans," "health insurers," and "insurers" are used interchangeably.
5. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).
6. In New York, the following types of plans must provide MH and SUD benefits in addition to complying with the federal parity law. This is because they are considered Essential Health Benefits (EHBs) under the ACA: (1) Individual and small employer plans bought on the health insurance marketplace (New York State of Health), and those not bought on the health insurance marketplace, unless they are "grandfathered"; and (2) Medicaid Alternative Benefit Plans (ABPs), including those for newly eligible Medicaid beneficiaries under the ACA or the "expansion population," regardless of how services are delivered.
7. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147), https://www.federalregister.gov/articles/2013/11/13/2013-27086/final-rules-under-

the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act.

8. The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (Mar. 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440, 456, et al.), https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.
9. 29 U.S.C. § 1185a(a)(3); 26 U.S.C. § 9812(a)(3); 42 U.S.C. § 300gg-26(a)(3).
10. 29 U.S.C. § 1185a(a)(3); 26 U.S.C. § 9812(a)(3); 42 U.S.C. § 300gg-26(a)(3).
11. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68245.
12. Note that the final regulations implementing the federal parity law also provide guidance on how to determine the predominant level of a financial requirement or treatment limitation if no one level applies to more than one-half of the medical/surgical benefits in a classification.
13. 29 U.S.C. § 1185a(a); 42 U.S.C. § 300gg-26(a)(3); 26 U.S.C. § 9812(a).
14. *See, e.g.*, Ctr. for Consumer Info. & Insurance Oversight, Information on Essential Health Benefits Benchmark Plans, https://www.cms.gov/cciio/resources/data-resources/ehb.html.
15. *See* NY Dep't of Fin. Servs., Accident & Health Product Filing, Model Language, Mental Health & Substance Use (Apr. 24, 2015), http://www.dfs.ny.gov/insurance/health/model_lang_indx.htm; Ctrs. for Medicare & Medicaid Servs., 2014 – 2016 Summary of EHB Benchmark Plan Benefits, Limits, & Prescription Drug Coverage, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-New-York-Benchmark-Summary.pdf; *see also*, Ctrs. for Medicare & Medicaid Servs., State-Required Benefits, https://downloads.cms.gov/cciio/State%20Required%20Benefits_NY.PDF.
16. *See, e.g.*, 29 U.S.C. § 1185a(a)(4); 42 U.S.C. § 300gg-25(a)(4); 26 U.S.C. § 9812(a)(4); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68274 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).
17. FEHB Program Carrier Letter, Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equity Act of 2008 – Federal Employees Health Benefits Program Carrier Guidance, Letter No. 2008-17 (Nov. 10, 2008), https://www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf.
18. *See, e.g.*, N.Y. Dep't of Health, A Plan to Transform the Empire State's Medicaid Program, https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf; N.Y. Dep't of Health, MRT Managed Care Benefit & Population Expansion (Sept. 30, 2015), http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt1458_timeline.pdf.
19. *See* N.Y. Dep't of Health, Behavioral Health Transition to Managed Care, https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health.
20. *See* 42 C.F.R. § 438.920(a); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (Mar. 30, 2016).
21. *See* The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18404 (Mar. 30, 2016).
22. Although TRICARE plans are not required to follow the federal parity law, the Department of Defense released proposed regulations in February 2016 that aim to bring TRICARE plans into compliance with parity. *See* TRICARE; Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 5061 (Feb. 1, 2016) (to be codified at 32 C.F.R. pt. 199), https://www.federalregister.gov/

articles/2016/02/01/2016-01703/tricare-mental-health-and-substance-use-disorder-treatment.

23. Parity in Mental Health and Substance Use, 29 C.F.R. § 2590.712(g); Parity in Mental Health and Substance Use Disorder Benefits, 26 C.F.R. § 54.9812-1; Internal Claims and Appeals and External Review Processes, 45 C.F.R. § 147.136. Note that health insurance plans that qualify for the increased cost exemption and choose to implement it must notify plan participants and beneficiaries. *See* 29 C.F.R. § 2590.712(g)(6).
24. For a list of state and local government plans that have opted out of the federal parity law, *see* HIPAA Opt-Out Elections for Self-Funded, Non-Federal Governmental Plans, http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa-nfgp-list-7-9-2013.pdf.
25. *See* TRICARE; Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 5061 (Feb. 1, 2016) (to be codified at 32 C.F.R. pt. 199).
26. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).
27. *See* 29 C.F.R. § 2590.712(c)(2)(i); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
28. *See* The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18395 (Mar. 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440, 456, et al.); *see also* Medicaid & Children's Health Insurance Programs; Mental Health Parity & Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans; Proposed Rule, 80 Fed. Reg. 19417, 19424 (Apr. 10, 2015) (to be codified at 42 C.F.R. pts. 438, 440, 456, et al.).
29. *See* 29 C.F.R. § 2590.712(c)(2).
30. *Id.*
31. 29 C.F.R. § 2590.712(c)(2)(ii)(A); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
32. 29 C.F.R. § 2590.712(c)(2)(ii)(B); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
33. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 at 68243; 29 C.F.R. § 2590.712(c)(3); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
34. *See* 29 C.F.R. § 2590.712(c)(3)(i)(A); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
35. *See* 29 C.F.R. § 2590.712(c)(3)(i)(B); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
36. *See* 29 C.F.R. § 2590.712(c)(3); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 438.910, 457.496, 440.395.
37. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 at 68245; The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 at 18399; 29 C.F.R. § 2590.712(c)(4)(i); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 438.910, 457.496, 440.395.
38. 29 C.F.R. § 2590.712(c)(4); 26 C.F.R. § 54.9812-1; 42 C.F.R. § 438.910. Note, however, that the regulations applying the federal parity law to Medicaid and CHIP allow quantitative treatment limitations (though not financial requirements) to accumulate separately for MH/SUD and medical/surgical benefits. *See* The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 at 18398-18399.
39. 29 C.F.R. § 2590.712(c)(3)(iii); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 483.910, 457.496, 440.395.

40. 29 C.F.R. § 2590.712(c)(3)(iii)(B); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 483.910, 457.496, 440.395.
41. 29 C.F.R. § 2590.712(c)(3)(iii)(C); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 483.910, 457.496, 440.395.
42. 29 C.F.R. § 2590.712(c)(3)(iii)(C); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
43. 29 C.F.R. § 2590.712(c)(3)(v); 26 C.F.R. § 54.9812-1.
44. *See* The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 at 18398-18399.
45. *See* 29 U.S.C. § 1185a(a)(4); 42 U.S.C. § 300gg-26(a)(4); 26 U.S.C. § 9812(a)(4); 29 C.F.R. § 2590.712(d)(1); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. at 68247; The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 at 18407.
46. *See, e.g.*, Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. at 68274; The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 at 18407.
47. *Id.* at 68274.
48. *See* 29 C.F.R. § 2590.712(d)(3); *see also* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program 78 Fed. Reg. at 68247.
49. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. at 68248, n.27 (citing Contents of Summary Plan Description, 29 C.F.R. § 2560.102-3(j); Amendment to the Summary Plan Description Regulations, 65 Fed. Reg. 70226, 70237; 96-14A Op. ERISA Sec. 104(b) (1996), http://www.dol.gov/ebsa/programs/ori/advisory96/96-14a.htm).
50. 29 U.S.C. § 1185a(a)(4); 42 U.S.C. § 300gg-26(a)(4); 26 U.S.C. § 9812(a)(4); 29 C.F.R. § 2590.712(d); 42 C.F.R. §§ 439.915(b), 440.395(d)(2), 457.496(e)(2); *see also* 78 Fed. Reg. 68240-01, 68247.
51. *See* David Machledt et al., A Guide to Oversight, Transparency, & Accountability in Medicaid Managed Care, NATIONAL HEALTH LAW PROGRAM (Mar. 9, 2015), http://www.healthlaw.org/publications/managed-care-toolkit-march-2015#.VgSAVRHBwXA.
52. *See* U.S. Dep't of Labor, FAQs About Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation, (Oct. 23, 2015), http://www.dol.gov/ebsa/faqs/faq-aca29.html; Centers for Medicare & Medicaid Servs., FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation (Apr. 20, 2016), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf.
53. Telephone interview with Tom Fusco, Supervising Insurance Attorney, N.Y. Dep't of Fin. Servs., & Tammy Oliver, Associate Insurance Examiner, N.Y. Dep't of Fin. Servs. (Feb. 26, 2016).
54. *See* N.Y. Ins. Law §§ 3216(i)(30)(A), 3216(i)(31)(A). Note that this requirement applies to health insurance plans that provide hospital, major medical, or similar comprehensive coverage. *Id. See also* 11 N.Y.C.R.R. § 52.24.
55. *See* N.Y. Ins. Law §§ 3216(i)(31)(D), 3221(l)(7)(D).
56. *See* N.Y. Ins. Law §§ 3221(l)(5)(A)(i), 4303(g). Note that this requirement applies to health insurance plans that cover inpatient hospital care or that cover physician services. *Id.*
57. *See* N.Y. Ins. Law §§ 3221(l)(5)(A), 4303(g). Note that this requirement applies to health insurance plans that cover inpatient hospital care or that cover physician services. *Id.*

58. *See* N.Y. Ins. Law §§ 3221(l)(5)(A)(i), 4303(g). Note that this requirement applies to health insurance plans that cover inpatient hospital care or that cover physician services. *Id.*
59. "Biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Examples include schizophrenia, psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia. N.Y. Ins. Law §§ 3221(l)(5)(B)(ii); 4303(g)(2)(B).
60. "Children with serious emotional disturbances" means people under the age of 18 who have been diagnosed with attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and who also have one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household. N.Y. Ins. Law §§ 3221(l)(5)(C), 4303(g)(3).
61. *See* N.Y. Ins. Law §§ 3221(l)(5)(B); 4303(g)(2).
62. *See* N.Y. Ins. Law §§ 3216(i)(4), 3221(l)(4)(A), 3221(l)(4)(D); *see also* Letter from OASAS, https://www.oasas.ny.gov/regs/documents/InsReimbforCASACServices.pdf.
63. *See* N.Y. Ins. Law § 4903(c)(3); *see also* N.Y. Ins. Law § 4904(b).
64. *See* NY Dep't of Fin. Servs., Insurance Circular Letter No. 6 (2015) (Mar. 30, 2015), http://www.dfs.ny.gov/insurance/circltr/2015/cl2015_06.htm; *see also* March 11, 2015: OASAS: Level of Care Tools Used By Insurers for SUD, Post to 2015 State Agency News, N.Y. Council for Community Behavioral Healthcare (Mar. 11, 2015), http://www.nyscouncil.org/state-agency-news; *see also* April 28, 2015: OASAS Level of Care Tool, Post to 2015 State Agency News, N.Y. Council for Community Behavioral Healthcare (Apr. 28, 2015), http://www.nyscouncil.org/state-agency-news.
65. *See* N.Y. Ins. L. §§ 4903(e)(3), 3217-a(b)(10), 4324(b)(10); N.Y. Pub. Health L. §§ 4903(5)(c), 4408(2)(j); NY Dep't of Fin. Servs., Insurance Circular Letter No. 6 (2015) (Mar. 30, 2015), http://www.dfs.ny.gov/insurance/circltr/2015/cl2015_06.htm.
66. Telephone interview with Tom Fusco, Supervising Insurance Attorney, N.Y. Dep't of Fin. Servs., & Tammy Oliver, Associate Insurance Examiner, N.Y. Dep't of Fin. Servs. (Feb. 26, 2016).
67. *See* Transitioning Behavioral Health Services Into NYC Medicaid Managed Care SUD Statutory; Regulatory; and Contractual Provisions, N.Y. Office of Alcoholism & Substance Abuse Servs., p. 2, https://www.oasas.ny.gov/ManCare/documents/OASASMMCGuidance.pdf; *see also* March 11, 2015: OASAS: Level of Care Tools Used By Insurers for SUD, Post to 2015 State Agency News, N.Y. Council for Community Behavioral Healthcare (Mar. 11, 2015), http://www.nyscouncil.org/state-agency-news.
68. *See* Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. 72192, 72206-72211 (Nov. 18, 2015) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 144, 146, and 147); 29 C.F.R. §§ 2590.715-2719, 2560.503-1(b)(4), (h); 45 C.F.R. § 147.136; 42 U.S.C. § 300gg-19; N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; 42 C.F.R. §§ 438.400 *et seq.*; N.Y. Soc. Serv. L. §§ 22(3)-(5), 364-j(9); N.Y. Dep't of Health, Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract (Mar. 1, 2014), https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules, 80 Fed. Reg. 31908 (Jun. 1, 2015) (to be codified at 42 C.F.R. pts. 431, 433, 438 et al.); 5 C.F.R. § 890.105; *see also* Samuel C. Salganik, "Health Plan Appeal Rights

in New York After the Affordable Care Act," NYSBA Health Law Journal, Vol. 17 No. 1 (Winter 2012), http://www.wnylc.com/health/afile/170/331; Empire Justice Center, Child Health Plus in New York: A Program Primer, http://www.wnylc.com/health/entry/93; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43330 (proposed Jul. 23, 2010) (to be codified at 26 C.F.R. pts. 54 & 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147); Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37208 (proposed Jun. 24, 2011) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147); Claims Procedure for Plans Providing Disability Benefits, 80 Fed. Reg. 72014 (proposed Nov. 18, 2015) (to be codified at 29 C.F.R. pt. 2560); MaryBeth Musumeci, A Guide to the Medicaid Appeals Process (The Henry J. Kaiser Family Foundation, March 2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf; N.Y. Dep't of Health, "New York State Managed Care Model Member Handbook – Revised for 2010," https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_model_member_handbook.pdf.

69. *See* 29 C.F.R. §§ 2560.503-1(h), (m)(4), 2590.715-2719(b); N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; 5 C.F.R. § 890.105; *see also* Salganik, *supra* note 61, at 34.
70. *See* 75 Fed. Reg. 43330, 43332; 80 Fed. Reg. 72192, 72207; Healthcare.gov, Internal Appeals, https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals; N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; *see also* Salganik, *supra* note 61, at 36.
71. 80 Fed. Reg. 72192, 72207.
72. *See* 42 C.F.R. § 438.400(b); N.Y. Soc. Serv. L. §§ 22(3)-(5), 364-j(9); *see also* N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf; MaryBeth Musumeci, A Guide to the Medicaid Appeals Process (The Henry J. Kaiser Family Foundation, March 2012), p. 21, available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf.
73. *See* 42 C.F.R. §§ 457.1130(b); N.Y. Pub. Health L. §§ 4904, 4900; *see also* Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at http://www.wnylc.com/health/entry/93.
74. *See* 29 C.F.R. § 2560.503-1(h), (m)(4); N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; 42 C.F.R. § 438.404.
75. *See* 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(3); 80 Fed. Reg. 72192; N.Y. Ins. L. § 4904(c).
76. *See* 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
77. *See* 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
78. *See* 29 C.F.R. § 2560.503-1(h)(3)(i).
79. *Id.*
80. *Id.*
81. *See* 5 C.F.R. § 890.105.
82. *See* N.Y. Ins. L. § 4904(c).
83. *See* N.Y. Ins. L. § 4904(c).
84. N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.
85. *See* N.Y. Pub. Health L. § 4904(3); *see also* Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at http://www.wnylc.com/health/entry/93.
86. *See* 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(3); 80 Fed. Reg. 72192.
87. *See* 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
88. *See* 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
89. *See* 29 C.F.R. § 2560.503-1(i)(2), (j); N.Y. Ins. L. § 4904(c).

90. *See* 29 C.F.R. § 2560.503-1(i)(2), (j).
91. *See* 29 C.F.R. § 2560.503-1(i)(2), (j).
92. *See* 5 C.F.R. § 890.105.
93. *See* N.Y. Ins. L. § 4904.
94. *See id.*
95. *See* N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf; *see also* 42 C.F.R. § 438.408.
96. *See* N.Y. Pub. Health L. § 4904(3); *see also* Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at http://www.wnylc.com/health/entry/93.
97. *See* 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1); 45 C.F.R. § 147.136(b)(3); N.Y. Ins. L. § 4904(b), 4903(c).
98. *See* 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192; N.Y. Ins. L. § 4904(b), 4903(c).
99. *See* 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192; N.Y. Ins. L. § 4904(b), 4903(c).
100. *See* N.Y. Ins. L. §§ 4904(b), 4903(c); 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), 2590.715-2719(b)(2)(ii)(B).
101. *See* 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), 2590.715-2719(b)(2)(ii)(B).
102. *See* 29 C.F.R. § 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1).
103. *See* N.Y. Ins. L. §§ 4904(b), 4903(c).
104. *See id.*
105. *See* 42 C.F.R. §§ 438.400(b)(3), 438.410; N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.
106. *See* N.Y. Pub. Health L. § 4904(2), 4903(3); 42 C.F.R. § 457.1160(b); *See* also Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at http://www.wnylc.com/health/entry/93.
107. *See* N.Y. Ins. L. §§ 4903(b)-(c); N.Y. Pub. Health L. §§ 4903(2)-(3); NY Dep't of Fin. Servs., Insurance Circular Letter No. 6 (2015) (Mar. 30, 2015), http://www.dfs.ny.gov/insurance/circltr/2015/cl2015_06.htm.
108. *See* 29 C.F.R. §§ 2560.503-1(i)(2), (j), 2590.715-2719(b)(2)(E); 45 C.F.R. § 147.136(b)(2)(E); N.Y. Ins. L. § 4904(c); N.Y. Pub. Health L. § 4904(3); Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43333-43334; 76 C.F.R. § 37208-01, 37210; 42 C.F.R. § 438.408; N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf; 5 C.F.R. § 890.105.
109. *See* 29 C.F.R. §§ 2560.503-1(j), 2590.715-2719(b)(2)(E); 45 C.F.R. § 147.136(b)(2)(E).
110. *See* 42 C.F.R. § 438.408; N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.
111. *See, e.g.*, 29 C.F.R. § 2590.715-2719(b)(2)(E).
112. *See* N.Y. Ins. L. §§ 4914(b); N.Y. Pub. Health L. § 4914(b); 29 C.F.R. §§ 2560.503-1(j), 2590.715-2719(b)(2)(E); 45 C.F.R. § 147.136(b)(2)(E); 42 C.F.R. § 438.408(d).
113. *See* N.Y. Ins. L. § 4904(b); N.Y. Pub. Health L. § 4914(2).
114. *See* N.Y. Ins. L. §§ 4904(b), 4910(b)(1)(B); N.Y. Pub. Health L. §§ 4904(2), 4910(2)(a)(ii); Healthcare.gov, "Internal Appeals," https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals.
115. Although self-insured large group plans that are grandfathered are not legally required to provide an external appeal/review process, these plans may provide one anyway. You should check with your plan to find out whether you can file an external appeal/review.
116. *See* N.Y. Ins. L. §§ 4910, 4914; N.Y. Pub. Health L. §§ 4910, 4914; N.Y. Dep't of Fin. Servs., New York State External Appeal, http://www.

dfs.ny.gov/insurance/extapp/extappqa.htm; 29 C.F.R. § 2590.715-2719(d); 45 C.F.R. § 147.136(d); Ctr. for Consumer Info. & Insurance Oversight, Affordable Care Act: Working with States to Protect Consumers, http://www.cms.gov/CCIIO/Resources/Files/external_appeals.html; N.Y. Dep't of Health, Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract (Mar. 1, 2014), p. 14, § 35.10, https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans in N.Y. to comply with N.Y. Pub. Health L. external appeal/review provisions).

117. *See* N.Y. Ins. L. §§ 4904(c)(2), 4910, 4914; N.Y. Pub. Health L. §§ 4904(c)(2), 4910, 4914; 29 C.F.R. §§ 2590.715-2719(d), (b)(2)(ii)(E)(4); N.Y. Soc. Serv. L. § 364-j(9); N.Y. Dep't of Health, Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract (Mar. 1, 2014), p. 14 § 35.10, available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans in N.Y. to comply with N.Y. Pub. Health L. external appeal/review provisions); 5 C.F.R. § 890.105; *see also* Salganik *supra* note 61.
118. *See* N.Y. Ins. L. § 4910(b); N.Y. Pub. Health L. § 4910(2); 29 C.F.R. § 2590.715-2719(d)(1); N.Y. Dep't of Health, "Medicaid Managed Care/ Family Health Plus/ HIV Special Needs Plan Model Contract," Sec. 35.10 (Mar. 1, 2015), available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans to comply with the N.Y. Public Health Law's external appeal provisions); 5 C.F.R. 890.105(e).
119. *See* 29 C.F.R. § 2590.715-2719(d)(1)(i)(A).
120. *See id.*
121. *See* N.Y. Ins. L. § 4910; 45 C.F.R. § 147.136; *see also* 80 Fed. Reg. 72192.
122. *See id.*
123. *See* N.Y. Ins. L. § 4910; 29 C.F.R. § 2590.715-2719(c); *see also* 80 Fed. Reg. 72192.
124. *See* 29 C.F.R. § 2590.715-2719(d); *see also* 80 Fed. Reg. 72192.
125. *See* 5 C.F.R. 890.105(e).
126. *See* N.Y. Ins. L. § 4910.
127. *See id.*
128. *See* N.Y. Pub. Health L. § 4910; N.Y. Dep't of Health, "Medicaid Managed Care/ Family Health Plus/ HIV Special Needs Plan Model Contract," Sec. 35.10 (Mar. 1, 2015), available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans to comply with the N.Y. Public Health Law's external appeal provisions).
129. *See* N.Y. Pub. Health L. § 4910; *see also* Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at http://www.wnylc.com/health/entry/93.
130. *See* N.Y. Ins. L. § 4914(b)(3); N.Y. Pub. Health L. § 4914(2)(c); 29 C.F.R. § 2590.715-2719(d)(3)(i); 45 C.F.R. § 147.136(c); N.Y. Dep't of Health, "Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract," Sec. 35.10 (Mar. 1, 2015), https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans to comply with the N.Y. Public Health Law's external appeal provisions).
131. *See* N.Y. Ins. L. § 4914(b)(3); N.Y. Pub. Health L. § 4914(2)(c); 29 C.F.R. § 2590.715-2719(d)(3)(i); 45 C.F.R. § 147.136(c).
132. *See* N.Y. Ins. L. §§ 4914(b)(3), 4904(b), 4910(b)(1)(B); N.Y. Pub. Health L. §§ 4914(2)(c), 4904(2), 4910(2)(a)(ii); 29 C.F.R. § 2590.715-2719(d)(3); 45 C.F.R. § 147.136(c).
133. *See* N.Y. Dep't of Fin. Servs., New York State External Appeal Application, http://www.dfs.ny.gov/insurance/extapp/extappl.pdf.
134. *See* 29 C.F.R. § 2590.715-2719(d)(1)(ii)(B).
135. *See* N.Y. Ins. L. § 4914; N.Y. Pub. Health L. § 4914; N.Y. Dep't of Fin. Servs., New York State External Appeal, http://www.dfs.ny.gov/insurance/extapp/extappqa.htm; 29 C.F.R. § 2590.715-2719(d)(2)(i);

N.Y. Dep't of Health, "Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan Model Contract," Sec. 35.10 (Mar. 1, 2015), available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans to comply with the N.Y. Public Health Law's external appeal provisions).

136. *See* 5 C.F.R. § 890.105(e).
137. *See* N.Y. Ins. L. § 4914; N.Y. Dep't of Fin. Servs., New York State External Appeal, http://www.dfs.ny.gov/insurance/extapp/extappqa.htm; Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. at 72211; Healthcare.gov, External Review, www.healthcare.gov/glossary/external-review; *see also* Ctr. for Consumer Info. & Insurance Oversight, Affordable Care Act: Working with States to Protect Consumers, https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.
138. *See* 80 Fed. Reg. 72192, 72211.
139. *See* 42 C.F.R. § 457.1130; N.Y. Pub. Health L. § 4910; *See* also Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at http://www.wnylc.com/health/entry/93.
140. *See* N.Y. Ins. L. §§ 4910, 4914; N.Y. Pub. Health L. §§ 4910, 4914; N.Y. Dep't of Fin. Servs., New York State External Appeal, http://www.dfs.ny.gov/insurance/extapp/extappqa.htm; N.Y. Dep't of Health, "Medicaid Managed Care/ Family Health Plus/ HIV Special Needs Plan Model Contract," Sec. 35.10 (Mar. 1, 2015), https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans to comply with the N.Y. Public Health Law's external appeal provisions).
141. *See* 29 C.F.R. §§ 2590.715-2719(c)(1)(iii), (d); 80 Fed. Reg. 72192, 72209; Ctr. for Consumer Info. & Oversight, Affordable Care Act: Working with States to Protect Consumers, http://www.cms.gov/CCIIO/Resources/Files/external_appeals.html; Healthcare.gov, "External Review," www.healthcare.gov/glossary/external-review.
142. *See* 5 C.F.R. § 890.105(e).
143. *See* N.Y. Ins. L. § 4914(b)(4); N.Y. Pub. Health L. § 4914(2)(d); N.Y. Dep't of Health, Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract, Sec. 35.10 (Mar. 1, 2015), https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans to comply with the N.Y. Public Health Law's external appeal provisions); 29 C.F.R. §§ 2590.715-2719(d)(2)(iii)(B)(5).
144. *See* N.Y. Ins. L. § 4914(b)(4)(A); N.Y. Pub. Health L. § 4914(2)(d).
145. *See* N.Y. Ins. L. § 4914(b)(4)(B); N.Y. Pub. Health L. § 4914(2)(d).
146. *See* N.Y. Ins. L. § 4914(b)(4)(C); N.Y. Pub. Health L. § 4914(2)(d).
147. *See* N.Y. Ins. L. § 4914(b)(4)(D); N.Y. Pub. Health L. § 4914(2)(d).
148. *See* 29 C.F.R. § 2590.715-2719(d)(2)(iii)(B)(5).
149. *See* 5 C.F.R. § 890.105(e).
150. *See* N.Y. Ins. L. § 4914(b)(2); N.Y. Pub. Health L. § 4914(2)(b); N.Y. Dep't of Health, "Medicaid Managed Care/ Family Health Plus/ HIV Special Needs Plan Model Contract," Sec. 35.10 (Mar. 1, 2015), https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf (requiring Medicaid Managed Care plans to comply with the N.Y. Public Health Law's external appeal provisions).
151. *See* 29 C.F.R. § 2590.715-2719(d)(2)(iii)(B)(6).
152. *See* 5 C.F.R. 890.105(e).
153. *See* N.Y. Ins. L. § 4914(b)(3); N.Y. Pub. Health L. § 4914(2)(c).
154. *See* N.Y. Ins. L. § 4914(b)(4); N.Y. Pub. Health L. § 4914(2)(d); 29 C.F.R. § 2590.715-2719(d)(2)(iii)(B)(7); 45 C.F.R. § 147.136(c); 5 C.F.R. 890.105(e).
155. *See id.*
156. *See id.*
157. *See id.*
158. *See* N.Y. Ins. L. § 4802.
159. *See* N.Y. Ins. L. § 4802.
160. *See* 42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. §§ 438.400 *et seq.*; N.Y. Soc. Serv. L. § 364-j(9).

161. *See* N.Y. Pub. Health L. § 4408-a; *see also* Empire Justice Center, "Child Health Plus in New York: A Program Primer," http://www.wnylc.com/health/entry/93.
162. *See* N.Y. Ins. L. § 4802; N.Y. Pub. Health L. § 4408-a; *see also* Empire Justice Center, "Child Health Plus in New York: A Program Primer", http://www.wnylc.com/health/entry/93.
163. *See* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 438.408; N.Y. Soc. Serv. L. § 22; 18 N.Y.C.R.R. § 358-3.1.
164. *See* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 438.400 *et seq.*; N.Y. Soc. Serv. L. § 364-j(9); 18 N.Y.C.R.R. §§ 360-10.8, 358-1.1 *et seq.*; *see also* Musumeci, *supra* note 61.
165. *See* 18 N.Y.C.R.R. § 358-3.6; *see also* Musumeci, *supra* note 61, at 10.
166. *See, e.g.*, 42 U.S.C. § 1396a(a)(3); Musumeci, *supra* note 61, at 6.
167. *See* N.Y. Soc. Serv. L. § 22(5); 18 N.Y.C.R.R. §§ 358-3.1(b), 360-10.8(b); Musumeci, *supra* note 61.
168. *See* N.Y. Soc. Serv. L. § 22(4)(a); 18 N.Y.C.R.R. § 358-3.5(b)(1).
169. *See* 18 N.Y.C.R.R. § 358-3.4(e).
170. *See* 18 N.Y.C.R.R. §§ 358-3.4, 358-3.6; Musumeci, *supra* note 61, at 10.
171. *See* 18 N.Y.C.R.R. § 358-3.6; *see also* Musumeci, *supra* note 61, at 10.
172. *See* 18 N.Y.C.R.R. § 358-3.2.
173. *See* Musumeci, *supra* note 61, at 11-13.
174. Telephone Interview with Tom Fusco, Supervising Insurance Attorney, N.Y. Dep't of Fin. Servs., & Tammy Oliver, Associate Insurance Examiner, N.Y. Dep't of Fin. Servs. (Feb. 26, 2016).
175. Telephone Interview with Vallencia Lloyd, Director, Division of Health Plan Contracting & Oversight, N.Y. Dep't of Health, Susan Bentley, Senior Attorney, N.Y. Dep't of Health, & Hope Goldhaber, N.Y. Dep't of Health (Mar. 25, 2015).
176. *See N.Y. State Psychiatric Ass'n, Inc. v. UnitedHealth Group*, 798 F.3d 125 (2d Cir. 2015).
177. *See* TRICARE; Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 5061 (Feb. 1, 2016) (to be codified at 32 C.F.R. pt. 199).
178. *See* 42 C.F.R. § 438.400(b).
179. *See* 29 C.F.R. § 2560.503-1; *see also* N.Y. Pub. Health L. § 4900(a); N.Y. Ins. L. § 4900(a).
180. *See* 29 C.F.R. § 2590.715-2719(b); 45 C.F.R. § 147.136(b); 26 C.F.R. § 54.9815-2719T(b).
181. *See* 45 C.F.R. § 147.136(b)(3)(ii)(A); Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. 72192, 72207 (Nov. 18, 2015) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 144, 146, and 147).
182. *See* 18 N.Y.C.R.R. § 358-3.6; Musumeci, *supra* note 61, at 10.
183. *See* 29 U.S.C. § 1185a(e)(1); 42 U.S.C. § 300gg-26(e)(1); 26 U.S.C. § 9812(e)(1); 29 C.F.R. § 2590.712(a); 45 C.F.R. § 146.136; 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 428.900, 457.496, 440.395.
184. *See* 29 U.S.C. § 1185a(e)(2); 42 U.S.C. § 300gg-26(e)2); 26 U.S.C. § 9812(e)(2); 29 C.F.R. § 2590.712(a); 45 C.F.R. § 146.136; 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 428.900, 457.496, 440.395.
185. *See, e.g.*, Healthcare.gov, Glossary, "Appeal," https://www.healthcare.gov/glossary/appeal.
186. *See, e.g.*, Healthcare.gov, Internal Appeals, https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals.
187. *See* 29 C.F.R. § 2590.712(c)(1)(i); 29 C.F.R. § 2590.712(c)(2)(ii); 45 C.F.R. § 146.136; 26 C.F.R. § 54.9812-1.
188. *See* 42 C.F.R. §§ 428.900, 457.496, 440.395; *see also* The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18395 (Mar. 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440, 456, *et al.*).
189. *See* Healthcare.gov, Glossary, "Coinsurance," https://www.healthcare.gov/glossary/co-insurance.
190. *See* Healthcare.gov, Glossary, "Copayment," https://www.healthcare.gov/glossary/co-payment.
191. *See, e.g.*, Free Dictionary, http://medical-dictionary.thefreedictionary.

com/concurrent+review.

192. *See* 29 C.F.R. § 2590.712(a); 45 C.F.R. § 146.136; 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 428.900, 457.496, 440.395.
193. *See* 29 C.F.R. § 2590.712(a); 45 C.F.R. § 146.136; 26 C.F.R. § 54.9812-1.
194. *See* Healthcare.gov, Glossary, https://www.healthcare.gov/glossary; U.S. Dep't of Labor, Glossary of Health Coverage & Medical Terms, http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf; Kaiser Family Foundation, Health Reform Glossary, http://kff.org/glossary/health-reform-glossary#glossary-d.
195. *See* 29 C.F.R. §§ 2560.503-1, 2590.715-2719; 45 C.F.R. § 147.136; N.Y. Ins. L. §§ 4904(b), 4903(c), 4914(b); N.Y. Pub. Health L. §§ 4904(2), 4902(3); 4914(2); 42 C.F.R. § 438.400; *see also* Healthcare.gov, "Internal Appeals," http://www.hhs.gov/healthcare/rights/appeal/appealing-health-plan-decisions.html; *see also* 76 Fed. Reg. 37208-01, 37212 (June 24, 2011).
196. *See* Healthcare.gov, Glossary, "External Review," www.healthcare.gov/glossary/external-review; N.Y. Pub. Health L. § 4910, 4914; N.Y. Ins. L. § 4910, 4914; N.Y. Soc. Serv. L. § 364-j.
197. *See, e.g.*, 26 C.F.R. § 54.9812-1(c)(4)(ii)(F).
198. *See, e.g.*, 42 U.S.C. § 1396a(a)(3); 18 N.Y.C.R.R. § 358-2.12; N.Y. Office of Temporary & Disability Assistance, Fair Hearings, available at https://otda.ny.gov/hearings; *see also* Musumeci, *supra* note 61, at 6.
199. *See* Medicaid.gov, Fee for Service, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/fee-for-service.html.
200. *See* 29 U.S.C. § 1185a(a)(3)(B)(i); 42 U.S.C. § 300gg-26(a)(3)(B)(i); 26 U.S.C. § 9812(a)(3)(B)(i); 29 C.F.R. § 2590.712; 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.900, 457.496, 440.395.
201. *See* 45 C.F.R. § 147.140; *see also* Healthcare.gov, "Grandfathered Health Insurance Plans," https://www.healthcare.gov/health-care-law-protections/grandfathered-plans.
202. *See* N.Y. Ins. L. § 4802; N.Y. Pub. Health L. § 4408-a; 42 U.S.C. § 1396u-2(b); 42 C.F.R. §438.400(b).
203. Healthcare.gov, Glossary, "Appeal," https://www.healthcare.gov/glossary/appeal.
204. *See* 42 U.S. § 300gg–91(e)(2); U.S. Substance Abuse & Mental Health Servs. Admin., Implementation of the Mental Health Parity & Addiction Equity Act, http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act.
205. 29 C.F.R. § 2590.712(c)(1)(iii); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395.
206. *See* Healthcare.gov, Glossary, "Lifetime Limit," https://www.healthcare.gov/glossary/life-time-limit; *see also* 42 C.F.R. §§ 428.900, 457.496, 440.395.
207. *See* U.S. Dep't of Health & Human Servs., Short-Term Analysis to Support Mental Health & Substance Use Disorder Parity Implementation (Feb. 2012), p. 5, (citing American Medical Ass'n Policy Statement, H-320.953 – Definitions of "Screening" & "Medical Necessity"), http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml.
208. 29 U.S.C. § 1185a(e)(3); 42 U.S.C. § 300gg-26(e)(3); 26 U.S.C. § 9812(e)(3); *see also* 42 C.F.R. §§ 428.900, 457.496, 440.395.
209. 29 C.F.R. § 2590.712(a); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.900, 457.496, 440.395.
210. Healthcare.gov, Glossary, "Medically Necessary," https://www.healthcare.gov/glossary/medically-necessary.
211. 29 U.S.C. § 1185a(e)(4); 42 U.S.C. § 300gg-26(e)(4); 26 U.S.C. § 9812(e)(4); *see also* 42 C.F.R. §§ 428.900, 457.496, 440.395.
212. *See* 29 C.F.R. § 2590.712(a); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.900, 457.496, 440.395.
213. Healthcare.gov, Glossary, "Network," https://www.healthcare.gov/glossary/network.
214. *See* 29 C.F.R. § 2590.712(c)(4); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395.
215. *See* Healthcare.gov, Glossary, https://www.healthcare.gov/glossary; U.S. Dep't of Labor, Glossary of Health Coverage & Medical Terms, http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf; Kaiser Family Foundation, Health Reform Glossary, http://kff.org/glossary/

healthreform-glossary/#glossary-o.

216. 29 U.S.C. § 1185a(a)(3)(B)(ii); 42 U.S.C. § 300gg-26(a)(3)(B)(ii); 26 U.S.C. § 9812(a)(3)(B)(ii).
217. 29 C.F.R. § 2590.712(c)(3)(i)(B); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395.
218. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68245 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).
219. *See* 29 C.F.R. § 2590.712(c)(4); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395.
220. 29 C.F.R. § 2590.712(c)(3)(i)(B)(2); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395.
221. *See* 29 C.F.R. § 2590.712(a); 26 C.F.R. § 54.9812-1(a); 45 C.F.R. § 147.136(a); 42 C.F.R. §§ 428.900, 457.496, 440.395.
222. *See* 29 C.F.R. § 2590.715-2719(a)(2)(i) (citing 29 C.F.R. § 2590.715-2712).
223. *See* 42 U.S. § 300gg–91(e)(4); U.S. Substance Abuse & Mental Health Servs. Admin., Implementation of the Mental Health Parity & Addiction Equity Act, http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act.
224. 29 C.F.R. § 2590.712(c)(3)(iii)(C); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395; *see also* The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18398 (Mar. 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440, 456, *et al.*).
225. 29 C.F.R. § 2590.712(c)(3)(iii)(B); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
226. 29 U.S.C. § 1185a(e)(5); 42 U.S.C. § 300gg-26(e)(5); 26 U.S.C. § 9812(e)(5); 42 C.F.R. §§ 428.900, 457.496, 440.395.
227. 29 C.F.R. § 2590.712(a); 26 C.F.R. § 54.9812-1(a); 45 C.F.R. § 147.136(a); 42 C.F.R. §§ 428.900, 457.496, 440.395.
228. *See* 29 C.F.R. § 2590.712(c)(3); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395.
229. 29 U.S.C. § 1185a(a)(3)(B)(iii); 42 U.S.C. § 300gg-26(a)(3)(B)(iii); 26 U.S.C. § 9812(a)(3)(B)(iii); 29 C.F.R. § 2590.712(a).
230. 29 C.F.R. § 2590.712(a); 26 C.F.R. § 54.9812-1(a); 45 C.F.R. § 147.136(a); 42 C.F.R. §§ 428.900, 457.496, 440.395.
231. 29 C.F.R. § 2590.712(c)(1)(ii); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136; 42 C.F.R. §§ 428.910, 457.496, 440.395.
232. *See* N.Y. Pub. Health L. § 4900(8); N.Y. Ins. L. § 4900(h).

12 Resources

ADDITIONAL RESOURCES

1. New York State Office of the Attorney General, Mental Health Parity Laws: Ensuring Equal Access to Treatment Coverage (brochure).
2. New York State Office of the Attorney General, Mental Health Parity Laws: Ensuring Equal Access to Treatment Coverage (flyer for providers).
3. New York State Office of Alcoholism and Substance Abuse Services, Understanding Your Rights For Substance Use Disorder Treatment and Insurance Coverage.
4. New York State Department of Financial Services, Helpful Hints for Completing the External Appeal Application.
5. New York State Department of Financial Services, New York State External Appeal Application.
6. New York State Department of Financial Services, Insurance Circular Letter No. 5 (2014).
7. New York State Department of Financial Services, Insurance Circular Letter No. 6 (2015).
8. United States Office of Personnel Management, FEHB Program Carrier Letter No. 2008-17 (Nov. 10, 2008).
9. New York State Office of Alcoholism and Substance Abuse Services, Letter regarding insurance coverage for services provided by CASACs.

HELPFUL WEBSITES

1. Legal Action Center, Parity and Health Care Access Resources.
2. ParityTrack.org
3. United States Substance Abuse and Mental Health Services Administration, Implementation of the Mental Health Parity and Addiction Equity Act.
4. Coalition for Whole Health
5. Parity Implementation Coalition

13 Sample Appeals, Complaints, & Letters[1]

This section contains sample appeals, complaints, and other letters for both patients and providers (which can be adapted for use by advocates, family members, and others). Choose the appropriate sample from the list on the right and modify it for your situation. When text is gray and bracketed, you need to modify it or, in some cases, decide whether to include it based on your individual circumstances. Click the links at the bottom of each sample to download a Word version that you can edit.

For every appeal, complaint or letter:

- Patients and providers should coordinate about who is filing appeals.
- Make copies of everything, and keep them in a safe place.
- Call Community Health Advocates at 1-888-614-5400 if you need help.

Please read the additional tips prior to each sample.

1. Internal Appeal Letter
- a. Sample Patient Internal Appeal (Parity)
- b. Sample Provider Letter In Support of Patient Internal Appeal (Parity)
- c. Sample Provider Internal Appeal (Parity)

2. External Appeal Letter
- a. Sample Patient External Appeal (Parity)
- b. Sample Provider External Appeal (Parity)

3. Request Letter for Information/Documents
- a. Sample Patient Request for Documents (Parity)
- b. Sample Provider Request for Documents (Parity)

4. Complaint Letter to State Government Agencies
- a. Sample Patient Complaint to State Government Agency (Parity)
- b. Sample Provider Complaint to State Government Agency (Parity)

5. Complaint Letter to Federal Government Agencies
- a. Sample Patient Complaint to Federal Government Agency (Parity)
- b. Sample Provider Complaint to Federal Government Agency (Parity)

1. Thank you to the Community Service Society's Community Health Advocates for sharing their sample internal appeals and tips, which we incorporated into our sample appeals.

a. Sample Patient Internal Appeal (Parity)

Tip For Patients Filing Internal Appeals

» Get a letter of support from your treating provider with supporting medical records.

Sample Patient Internal Appeal (Parity)

[Date]

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

[Your Name]
[Your Address]

[Your Insurance Plan's Address for Appeals]

Re: *[Patient's Name]*
Insurance ID Number: *[Patient's Insurance ID #]*
Date of Birth: *[Patient's Date of Birth]*
Claim Number: *[Claim # from Patient's Explanation of Benefits or Denial Letter]*
*[**If Patient Has Already Received the Service**]* **Date of Service:** *[The Date Patient Received the Services That Were Denied (Check Your Bill or Denial Letter If You Are Not Sure)]*
Provider: *[Name of Doctor and/or Hospital]*

To Whom It May Concern:

I am writing to appeal your denial of coverage or payment for the above-referenced service. *[**If urgent:** I have an urgent health situation and I am filing an expedited appeal pursuant to my rights under state and federal law.[1]] [**If you are appealing the denial of inpatient substance use disorder treatment and patient's plan is protected by New York State law (see** Section 6**):** Because I am appealing the denial of inpatient substance use disorder treatment, you are required by law to make a decision on this appeal within 24 hours.]* **The above-referenced services are medically necessary, and are not experimental or investigational. Please see the enclosed letter from my treating provider for additional explanation.**

Furthermore, your denial of coverage or payment for the above-referenced services appears to violate the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("federal parity law")[2]. The federal parity law requires health insurance plans that provide substance use disorder and mental health benefits to provide them at parity with other medical and surgical benefits. *[**If patient's plan is protected by New York State law (see** Section 6**):** New York State also has laws requiring health plans to cover substance use disorder and mental health benefits at parity with other medical and surgical benefits, and [Name of Patient's Health Insurance Plan] appears to be violating those laws as well.]*

*[**If Patient's Plan Has an Annual or Lifetime Limit for SUD/MH Benefits:** The Affordable Care Act forbids health plans from placing annual or lifetime limits on anything considered an "essential health benefit." In New York, inpatient and outpatient mental health and substance use disorder treatment are considered "essential health benefits." Therefore, [Name of Patient's Health Insurance Plan] is violating the Affordable Care Act by placing annual or lifetime limits on [Insert Treatment Type].]*

*[**Now Tell Your Story**: Describe your mental health or substance use disorder and the treatment you need. Explain what happens when you do not have treatment and why it is important that you receive the treatment.]*

I respectfully request that you cover the above-referenced service, and that you provide me with a written explanation of how *[Name of Patient's Health Insurance Plan]* **does or does not comply with the federal parity law. If you have any questions, you can reach me at** *[Phone # and/or Email Address]***.**

Sincerely,

[Your Name]

*[**If You Are Attaching Documentation, Like a Letter from Your Provider:** Enclosure]*

1. *See* N.Y. Insurance Law § 4904(b).
2. *See* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3881 (2008); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (March 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440 456, et al.).

DOWNLOAD TEMPLATE
Patient Internal Appeal

b. Sample Provider Letter In Support Of Patient Internal Appeal (Parity)

Tips For Provider Letters in Support of Patient Internal Appeals (Parity)

» Provide detail, including: patient's medical history; patient's condition and recommended treatment; if relevant, unsuccessful attempts at treating the condition; why alternative treatments are inferior.

» Explain why the treatment is medically necessary. If time permits, request that the health plan provide you with the medical criteria it is using (you are legally entitled to this information—see Section 4–B for more information). If you are unable to get a copy of the plan's medical necessity criteria, you can explain that the treatment is medically necessary because it will: prevent illness or disability; ameliorate the effects of an illness; allow patient to maintain maximum functional capacity; and/or standard treatments have failed.

» Note if the plan is applying its medical necessity criteria incorrectly. For example, the denial letter says treatment is not medically necessary because the patient is not exhibiting withdrawal symptoms, but the plan's medical necessity criteria for the treatment requested do not require patient to be exhibiting withdrawal symptoms.

Sample Provider Letter In Support Of Patient Internal Appeal (Parity)

[Print on Your Letterhead]
[Date]

[Patient's Insurance Plan's Address for Appeals]

Re: *[Patient's Name]*
Insurance ID Number: *[Patient's Insurance ID #]*
*[**If Patient Has Already Received the Service**]* **Date of Service:** *[The Date Patient Received the Services That Were Denied]*

To Whom It May Concern:

I am writing to request that you cover the services that I have recommended for my patient, *[Patient's Name]***.** *[Patient's Name]* **has been diagnosed with** *[Diagnosis]* **and, accordingly, I recommend** *[Recommended/ Denied Treatment]***.**

This recommended treatment is medically necessary for *[Patient's Name]* **because:** *[Insert Specific Reasons Why You Are Recommending This Treatment for This Patient. If Possible, Cite the Health Plan's Medical Necessity Criteria and Explain How This Patient Specifically Meets Those Criteria. If Possible, Include/ Attach Studies Showing This Treatment's Effectiveness. See "Tips for Writing Letter in Support of Patient's Internal Appeal" for More Guidance on What to Write Here.]*

Furthermore, the Mental Health Parity and Addiction Equity Act of 2008 requires you to cover mental health and substance use disorder benefits equally with other medical and surgical benefits. By denying coverage of this recommended treatment, you may be violating the law.

I respectfully request that you cover the recommended services. If you have any questions, you can reach me at *[Phone #]***.**

Sincerely,

[Your Name]
[Title]

*[**If You Are Attaching Documentation:** Enclosure]*

DOWNLOAD TEMPLATE
Provider Letter Support Patient Internal Appeal

c. Sample Provider Internal Appeal (Parity)

Tips For Providers Filing Internal Appeals (Parity)

» Provide detail, including: patient's medical history; patient's condition and recommended treatment; if relevant, unsuccessful attempts at treating the condition; why alternative treatments are inferior.

» Explain why the treatment is medically necessary. If time permits, request that the health plan provide you with the medical criteria it is using (you are legally entitled to this information—see Section 4–B for more information). If you are unable to get a copy of the plan's medical necessity criteria, you can explain that the treatment is medically necessary because it will prevent illness or disability, ameliorate the effects of an illness, allow patient to maintain maximum functional capacity, and/or standard treatments have failed.

» Note if the plan is applying its medical necessity criteria incorrectly. One such example would be if the denial letter says treatment is not medically necessary because the patient is not exhibiting withdrawal symptoms, but the plan's medical necessity criteria for the treatment requested do not require patient to be exhibiting withdrawal symptoms.

Sample Provider Internal Appeal (Parity)

[Print on Your Letterhead]

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

[Patient's Insurance Plan's Address for Appeals]

Re: *[Patient's Name]*
Insurance ID Number: *[Patient's Insurance ID #]*
Date of Birth: *[Patient's Date of Birth]*
Claim Number: *[Claim # from Patient's Explanation of Benefits or Denial Letter]*
*[**If Patient Has Already Received the Service**]* **Date of Service:** *[The Date Patient Received the Services That Were Denied]*
Provider: *[Name of Doctor and/or Hospital]*

To Whom It May Concern:

I am writing to appeal your denial of the coverage or payment for the above-referenced service for my patient, *[Patient's Name]***.** *[**If urgent:** [Patient's Name]'s health situation is urgent and I am filing an expedited appeal.] [**If you are appealing the denial of inpatient substance use disorder treatment and patient's plan is protected by New York State law (see Section 6):** Because I am appealing the denial of inpatient substance use disorder treatment, you are required by law to make a decision on this appeal within 24 hours.[1]] [Patient's Name]* **has been diagnosed with** *[Diagnosis]* **and, accordingly, I recommend** *[Recommended/Denied Treatment]***.**

This recommended treatment is medically necessary for *[Patient's Name]* **because:** *[Insert Specific Reasons Why You Are Recommending This Treatment for This Patient. If Possible, Cite the Health Plan's Medical Necessity Criteria and Explain How This Patient Specifically Meets Those Criteria. If Possible, Include/Attach Studies Showing This Treatment's Effectiveness. See "Tips for Writing Letter in Support of Patient's Internal Appeal" for More Guidance on What to Write Here.]*

Furthermore, your denial of coverage or payment for the above-referenced services appears to violate the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("federal parity law").[2] The federal parity law requires health insurance plans that provide substance use disorder and mental health benefits to provide them at parity with other medical and surgical benefits. *[**If patient's plan is protected by New York State law (see Section 6):** New York State also has laws requiring health plans to cover substance use disorder and mental health benefits at parity with other medical and surgical benefits, and [Name of Patient's Health Insurance Plan] appears to be violating those laws as well.]*

*[**If Patient's Plan Has an Annual or Lifetime Limit for SUD/MH Benefits:** The Affordable Care Act forbids health plans from placing annual or lifetime limits on anything considered an "essential health benefit." In New York, inpatient and outpatient mental health and substance use disorder treatment are considered "essential health benefits." Therefore, [Name of Patient's Health Insurance Plan] is violating the Affordable Care Act by placing annual or lifetime limits on [Insert Treatment Type].]*

I respectfully request that you cover the above-referenced service, and that you provide me with a written explanation of how *[Name of Patient's Health Insurance Plan]* **does or does not comply with the federal parity law. If you have any questions, you can reach me at** *[Phone # and/or Email Address]***.** *[**If Filing Expedited Appeal:** I am aware that you may need to contact me during non-business days for additional information. During non-business days, I can be reached at [Phone #]]***.**

Sincerely,

[Your Name]
[Title]

*[**If You Are Attaching Documentation:** Enclosure]*

1. *See* N.Y. Insurance Law § 4904(b).
2. *See* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3881 (2008); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (March 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440 456, et al.).

DOWNLOAD TEMPLATE
Provider Internal Appeal

a. Tips For Patients Filing External Appeals (Parity)

Tips For Patients Filing External Appeals (Parity)

- Get a letter of support from your treating provider with supporting medical records.
- If you are filing an external appeal/review with the NY Dept. of Financial Services (DFS), use the External Appeal Application (available on the DFS website) and attach this Sample Letter. You may submit the external appeal/review by fax or by certified or registered mail. If you are filing an **expedited** external appeal/review, you must also call DFS at (888) 990-3991 and tell them you are doing so, and you must complete the Physician Attestation (which starts on page 4 of the External Appeal Application). For more information, visit: http://www.dfs.ny.gov/insurance/extapp/extappqa.htm.
- If you are filing an external appeal/review with an Independent Review Organization (IRO), ask your health plan and the IRO how to file an external appeal/review. You can modify this sample letter and include it with your external appeal/review.

Sample Patient External Appeal (Parity)

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

[Date]
[Your Name]
[Your Address]

New York Department of Financial Services
P.O. Box 7209
Albany, NY 12224-0209
Fax: (800) 332-2729

Re: Attachment to External Appeal Application *[Patient's Name]*
Patient's Name: *[Patient's Name]*
Patient's Health Plan: *[Patient's Health Plan]*
Patient's Provider: *[Name and Phone # of Doctor and/or Hospital]*

To Whom It May Concern:

I am writing to appeal my health plan's denial of the coverage or payment for *[Insert Description of Denied Service]***.** ***[If urgent:*** *I have an urgent health situation and I am filing an expedited appeal pursuant to my rights under state and federal law.] [Denied Service]* **is medically necessary, and is not experimental or investigational. Please see the enclosed letter from my treating provider for additional explanation.**

Furthermore, my health plan's denial of coverage or payment for the above-referenced services appears to violate the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("federal parity law").[1] The federal parity law requires health insurance plans that provide substance use disorder and mental health benefits to provide them at parity with other medical and surgical benefits. ***[If patient's plan is protected by New York State law (see Section 6):*** *New York State also has laws requiring health plans to cover substance use disorder and mental health benefits at parity with other medical and surgical benefits, and [Name of Patient's Health Insurance Plan] appears to be violating those laws as well.]*

[If Patient's Plan Has an Annual or Lifetime Limit for SUD/MH Benefits: *The Affordable Care Act forbids health plans from placing annual or lifetime limits on anything considered an "essential health benefit." In New York, inpatient and outpatient mental health and substance use disorder treatment are considered "essential health benefits." Therefore, [Name of Patient's Health Insurance Plan] is violating the Affordable Care Act by placing annual or lifetime limits on [Insert Treatment Type].]*

[Now Tell Your Story: *Describe your mental health or substance use disorder and the treatment you need. Explain what happens when you do not have treatment and why it is important that you receive the treatment.]*

[If Plan Did Not Provide Documents/Information You Requested: *My plan also violated the federal parity law's (and other laws') requirement that it disclose certain information to me upon request. On [Date(s)] I requested that my plan provide me with [Insert Description of Documents/Information You Requested], which it is required by law to provide. The plan did not provide this information to me.]*

I respectfully request that you overturn my health plan's adverse benefit determination and require it to cover *[Denied Service]***. I also request that you provide me with a written determination as to whether my plan is in compliance with the federal parity law. If you have any questions, you can reach me at** *[phone # and/or email address]***.**

Sincerely,

[Your Name]

[If You Are Attaching Documentation, Like a Letter from Your Provider: *Enclosure]*

1. *See* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3881 (2008); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (March 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440 456, et al.).

DOWNLOAD TEMPLATE
Patient External Appeal

b. Sample Provider External Appeal (Parity)

Tips For Providers Filing External Appeals (Parity)

- Provide detail, including: patient's medical history; patient's condition and recommended treatment; if relevant, unsuccessful attempts at treating the condition; why alternative treatments are inferior.
- Explain why the treatment is medically necessary. If you were unable to get a copy of the plan's medical necessity criteria, you can explain that the treatment is medically necessary because it will: prevent illness or disability; ameliorate the effects of an illness; allow patient to maintain maximum functional capacity; and/or standard treatments have failed.
- Note if the plan is applying its medical necessity criteria incorrectly. For example, the denial letter says treatment is not medically necessary because the patient is not exhibiting withdrawal symptoms, but the plan's medical necessity criteria for the treatment requested do not require patient to be exhibiting withdrawal symptoms.
- If you are filing an external appeal/review with the NY Dept. of Financial Services (DFS), use the External Appeal Application (available on the DFS website) and attach this Sample Letter. You may submit the external appeal/review by fax or by certified or registered mail. If you are filing an **expedited** external appeal/review, you must also call DFS at (888) 990-3991 and tell them you are doing so, and you must complete the Physician Attestation (which starts on page 4 of the External Appeal Application). For more information, visit: http://www.dfs.ny.gov/insurance/extapp/extappqa.htm]
- If you are filing an external appeal/review with an Independent Review Organization (IRO), ask your health plan and the IRO how to file an external appeal/review. You can modify this sample letter and include it with your external appeal/review.

Sample Provider External Appeal (Parity)

[Print on Your Letterhead]

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

[Date]

New York Department of Financial Services
P.O. Box 7209
Albany, NY 12224-0209
Fax: (800) 332-2729

Re: Attachment to External Appeal Application
Patient's Name: *[Patient's Name]*
Patient's Health Plan: *[Patient's Health Plan]*

To Whom It May Concern:

I am writing to appeal *[Name of Health Plan]***'s denial of the coverage or payment for** *[Insert Description of Denied Service]***.** ***[If urgent:*** *[Patient's Name]'s health situation is urgent and I am filing an expedited appeal.]* *[Patient's Name]* **has been diagnosed with** *[Diagnosis]* **and, accordingly, I recommend** *[Recommended/Denied Treatment]***.**

This recommended treatment is medically necessary for *[Patient's Name]* **because:** *[Insert Specific Reasons Why You Are Recommending This Treatment for This Patient. If Possible, Cite to the Health Plan's Medical Necessity Criteria and Explain How This Patient Specifically Meets Those Criteria. If Possible, Include/Attach Studies Showing This Treatment's Effectiveness. See "Tips for Writing Letter in Support of Patient's Internal Appeal" for More Guidance on What to Write Here.]*

Furthermore, *[Name of Health Plan]***'s denial of coverage or payment for** *[Denied Service]* **appears to violate the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("federal parity law").[1] The federal parity law requires health insurance plans that provide substance use disorder and mental health benefits to provide them at parity with other medical and surgical benefits.** ***[If patient's plan is protected by New York State law (see Section 6):*** *New York State also has laws requiring health plans to cover substance use disorder and mental health benefits at parity with other medical and surgical benefits, and [Name of Patient's Health Insurance Plan] appears to be violating those laws as well.]*

*[**If Patient's Plan Has an Annual or Lifetime Limit for SUD/MH Benefits:** The Affordable Care Act forbids health plans from placing annual or lifetime limits on anything considered an "essential health benefit." In New York, inpatient and outpatient mental health and substance use disorder treatment are considered "essential health benefits." Therefore, [Name of Patient's Health Insurance Plan] is violating the Affordable Care Act by placing annual or lifetime limits on [Insert Treatment Type].]*

*[**If Plan Did Not Provide Documents/Information You Requested:** [Name of Health Plan] also violated the federal parity law's (and other laws') requirement that it disclose certain information to me upon request. On [Date(s)] I requested that [Name of Health Plan] provide me with [Insert Description of Documents/Information You Requested], which it is required by law to provide. The plan did not provide this information to me.]*

I respectfully request that you overturn *[Name of Health Plan]***'s adverse benefit determination and require it to cover** *[Denied Service]***. I also request that you provide me with a written determination as to whether** *[Name of Health Plan]* **is in compliance with the federal parity law. If you have any questions, you can reach me at** *[phone # and/or email address]***.**

Sincerely,

[Your Name]
[Title]

*[**If You Are Attaching Documentation:** Enclosure]*

1. *See* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3881 (2008); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (March 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440 456, et al.).

DOWNLOAD TEMPLATE
Provider External Appeal

a. Sample Patient Request for Documents (Parity)

Tips For Patients Requesting Documents (Parity)

» If possible, send your request by certified mail with return receipt requested. Be sure to keep the return receipt in a safe place.
» If you make this request by phone, record the date and time of your request, and the name of the person with whom you spoke.

Sample Patient Request For Documents (Parity)

[Date]

[Your Name]
[Your Address]

[Your Insurance Plan's Address]

Re: Patient's Name: *[Patient's Name]*
Insurance ID Number: *[Patient's Insurance ID #]*

To Whom It May Concern:

Pursuant to my rights under the Mental Health Parity and Addiction Equity Act, as well as other federal laws,[1] I am writing to request a copy of:

- **The medical necessity criteria you use when making medical necessity determinations about mental health and substance use disorder benefits. In particular, I am requesting the medical necessity criteria used to determine my eligibility for** *[Insert Denied MH/SUD Service]***.**
- **The medical necessity criteria you use when making medical necessity determinations about medical and surgical benefits. In particular, I am requesting the medical necessity criteria used for the medical or surgical benefit that you consider comparable to** *[Insert Denied MH/SUD Service]***.**
- **The processes, strategies, evidentiary standards, and other factors used to apply non-quantitative treatment limitations with respect to your mental health and substance use disorder benefits and your medical and surgical benefits. In particular, I am requesting this information with regard to** *[Insert Denied MH/SUD Service]* **and whatever medical or surgical benefit you consider comparable to** *[Insert Denied MH/SUD Service]***.**
- *[**If You Have Filed an Appeal:** All documents, records, and other information relevant to the claim I appealed on [Insert Date of Your Appeal] relating to Claim Number [Insert Claim # of the Claim the Insurer Denied and That You Appealed]***.**
- *[**If You Have Filed an Appeal:** The reason for your denial of [Insert Denied MH/SUD Service] on [Insert Date of Denial].]*
- *[**If You Are Trying to Access MH/SUD Medications, Such As Methadone]:** Whether, and under what circumstances, existing and new prescription drugs are covered by my health plan. [**Optional:** In particular, please explain whether, and under what circumstances, [Insert Name of Medication You Want to Access] is covered by my health plan.]]*

Please provide me with the information I have requested in this letter within 30 days. You may send the information to *[Insert Your Mailing Address]***.**

Sincerely,

[Your Name]

1. *See*, e.g., 29 U.S.C. § 1185a(a)(4); 42 U.S.C. § 300gg-26(a)(4); 26 U.S.C. § 9812(a)(4); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68240 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18407 (March 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440 456, et al.).

DOWNLOAD TEMPLATE
Patient Information Request for Documents

b. Sample Provider Request for Documents (Parity)

Tips For Providers Requesting Documents (Parity)

» If possible, send your request by certified mail with return receipt requested. Be sure to keep the return receipt in a safe place.

» If you make this request by phone, record the date and time of your request, and the name of the person with whom you spoke.

Sample Provider Request For Documents (Parity)

[Print on Your Letterhead; If No Letterhead, Write Provider Name & Address]

[Patient's Insurance Plan's Address]

Re: Patient's Name: *[Patient's Name]*
Insurance ID Number: *[Patient's Insurance ID #]*
Date of Birth: *[Patient's Date of Birth]*
Provider: *[Name of Doctor and/or Hospital]*

To Whom It May Concern:

I am a treating provider for *[Patient's Name]***. Pursuant to my rights under the Mental Health Parity and Addiction Equity Act, as well as other federal laws,[1] I am writing to request a copy of:**

- **The medical necessity criteria you use when making medical necessity determinations about mental health and substance use disorder benefits. In particular, I am requesting the medical necessity criteria used to determine** *[Patient's Name]***'s eligibility for** *[Insert Denied MH/SUD Service]***.**
- **The medical necessity criteria you use when making medical necessity determinations about medical and surgical benefits. In particular, I am requesting the medical necessity criteria used for the medical or surgical benefit that you consider comparable to** *[Insert Denied MH/SUD Service]***.**
- **The processes, strategies, evidentiary standards, and other factors used to apply non-quantitative treatment limitations with respect to your mental health and substance use disorder benefits and your medical and surgical benefits. In particular, I am requesting this information with regard to** *[Insert Denied MH/SUD Service]* **and whatever medical or surgical benefit you consider comparable to** *[Insert Denied MH/SUD Service]***.**
- *[**If You Or Your Patient Has Filed An Appeal:** All documents, records, and other information relevant to the claim I appealed on [Insert Date of Your Appeal] relating to Claim Number [Insert Claim # of the Claim the Insurer Denied and That You Appealed]**.]***
- *[**If You Or Your Patient Has Filed An Appeal:** The reason for your denial of [Insert Denied MH/SUD Service] on [Insert Date of Denial].]*
- *[**If Patient Is Trying to Access MH/SUD Medications, Such As Methadone**]: Whether, and under what circumstances, existing and new prescription drugs are covered by {Patient Name}'s health plan. {Optional: In particular, please explain whether, and under what circumstances, [Insert Name of Medication You Want to Access] is covered by [Patient Name]'s health plan.}]*

Please provide me with the information I have requested in this letter within 30 days. You may send the information to *[Insert Your Mailing Address]***.**

Sincerely,

[Your Name]
[Your Title]

1. *See*, e.g., 29 U.S.C. § 1185a(a)(4); 42 U.S.C. § 300gg-26(a)(4); 26 U.S.C. § 9812(a)(4); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68240 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18407 (March 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440 456, et al.).

DOWNLOAD TEMPLATE
Provider Information Request for Documents

a. Sample Patient Complaint to State Government Agency (Parity)

Tips For Patients Complaining To State Government Agencies (Parity)

- Send copies of supporting documents along with your complaint, including (where applicable): a copy of your insurance card; copies of denials/adverse benefit determinations by your plan; copies of the plan's and external review agent's determinations in any internal and external appeals; any materials you submitted with your appeals; supporting information from your health care provider; plan documents showing that the plan limits or excludes MH/SUD care; copies of the plan's medical necessity criteria; copies of any requests you made for information you are entitled to (like medical necessity criteria) and any responses you received from your plan.
- **If you are complaining to the NY Department of Financial Services (DFS)**, you should complete the DFS Complaint Form, available online, and submit the DFS Complaint Form together with your complaint based on this sample and your supporting documentation. You may submit the complaint online, by fax, or by mail. If you have any questions, you may call the DFS Consumer Assistance Unit at (800) 342-3736.
- **If you are complaining to the NY Department of Health (DOH)**, you should email your complaint based on this sample and your supporting documentation to managedcarecomplaint@health.ny.gov. If you do not have email access, you may send your complaint in the mail. If you have any questions, you may call DOH at (800) 206-8125.
- Legal Action Center is gathering information about possible parity violations in New York. If you are willing, please send us a copy of your complaint. We will keep your information confidential, and will only use the complaint for informational purposes. We will not be evaluating your complaint for possible representation. Please send the copy of your complaint either by email (send to lacinfo@lac.org with subject line "Parity Complaint"), fax (send to 212-675-0286; write ATTN: Parity Complaint), or mail (send to Parity Complaint, Legal Action Center, 225 Varick St. Suite 402, New York, NY 10014).

Sample Patient Complaint To State Government Agency (Parity)

[Date]

[Your Name]
[Your Address]

[Insurance Commissioner
New York Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Fax: (212) 480-6282]

[Medicaid Director
New York Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov]

Re: Possible Violation of Mental Health Parity & Addiction Equity Act

To Whom It May Concern:

I believe my health plan, *[Insert Your Health Plan Name]***, may be violating the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (federal parity law).** *[**Optional:** I also believe my health plan may be violating [**Insert One or More as Appropriate:** [New York State law] [the Affordable Care Act]]*. **The federal government has delegated primary enforcement of the federal parity law to the State Insurance Commissioners and Medicaid Directors.**

The federal parity law requires health plans that offer mental health (MH) and substance use disorder (SUD) benefits to offer them at parity with other medical and surgical benefits. Specifically, the law: (1) forbids plans from having any separate financial requirements or treatment limitations that apply only to MH/SUD benefits; (2) forbids plans from applying financial requirements or treatment limitations to MH/SUD benefits that are more restrictive than the predominant ones that are applied to substantially all medical/surgical benefits; (3) requires plans to provide out-of-network benefits for MH/SUD services if it offers them for medical/surgical services; and (4) requires plans to disclose medical necessity criteria and other information upon request.[1] The Affordable Care Act (ACA) incorporates the federal parity law and includes additional protections for people seeking MH/SUD care.

I believe that *[Insert Your Health Plan Name]* **may be violating the federal parity law by:** *[**Insert All That Apply**]*

- **Not covering residential treatment for** *[substance use disorder and/or mental health]***.**
- **Not covering** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]***.**
- **Limiting coverage of** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]* **by** *[Insert Description of Limitation (e.g., by only covering up to one year of methadone treatment for addiction)]***.**
- **Only covering** *[#]* **of days of** *[substance use disorder and/or mental health] [outpatient / inpatient / residential]* **treatment per year.**
- **Only covering** *[#]* **of visits to** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **treatment per year.**
- **Charging higher co-payments for** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **than for comparable medical/surgical services.** *[**Suggested:** Include Information About the Co-Payment You Are Being Charged for the MH/SUD Service and the Co-Payment You Are Being Charged for Comparable Medical/Surgical Service(s).]*
- **Charging a separate deductible for** *[substance use disorder and/or mental health]* **services and for medical/surgical services.**
- **Limiting how much it will pay** *[per year / in my lifetime]* **for** *[substance use disorder and/or mental health]* **services.** *[**Suggested:** The plan will only pay [Insert Amount] [per year / in my lifetime]* **for** *[substance use disorder and/or mental health services.]*
- **Requiring me to "fail first" at a lower level of care before approving a higher level of care.** *[**Suggested:** Explain Specifically What Your Plan Is Doing (e.g., the plan will only approve inpatient treatment if you fail first at outpatient treatment).]*
- **Refusing to cover** *[Insert MH/SUD Service]* **because I did not complete an earlier course of treatment.**
- **Refusing to cover** *[Insert MH/SUD Service]* **because the plan says I am not**

Complaint Letter to State Government Agencies

improving.

- » **Requiring more frequent** *[pre-authorization / concurrent review]* **for** *[Insert MH/SUD Service]* **than for medical/surgical services.** *[**Suggested:** Explain Specifically What Your Plan Is Doing (e.g., the plan is only approving one day of treatment at a time).]*
- » **Not having any** *[Insert Type of MH/SUD Provider]* **in its network.**
- » **Refusing to provide information I am entitled to upon request.** *[**Suggested:** On [Date(s)] I requested [Insert Type of Information Requested, e.g., medical necessity criteria] but my plan refused to provide it.]*
- » **Providing** *[insufficient and/or incorrect]* **information in denial letters.**
- » **Applying medical necessity criteria more restrictively to MH/SUD benefits than to medical/surgical benefits.** *[**If you know:** Explain in More Detail How Your Plan Is Applying Medical Necessity Criteria to the MH/SUD Benefit(s) You Requested.]*
- » **Refusing to cover out-of-state** *[mental health and/or substance use disorder]* **services, although it covers out-of-state medical/surgical services.**
- » *[Insert Any Other Actions by Your Plan That May Violate the Federal or State Parity Law(s), the ACA, and/or Other Laws.]*

I respectfully request that you investigate whether *[Insert Your Health Plan Name]* **is violating the federal parity law, and whether it is violating provisions of the Affordable Care Act (ACA) that guarantee access to MH/SUD care.** *[**If patient's plan is protected by New York State law (see** Section 6**):** Please also investigate whether [Insert Your Health Plan Name] is violating New York State law, including New York's parity law.]* **Please notify me in writing of your findings and any corrective action you take. If you need additional information, you can reach me at** *[Insert Phone # and/or Email Address and/or Address].*

Thank you for your assistance.

Sincerely,

[Name]

*[**If You Are Including Supporting Documentation:** Enclosure]*

1. *See* 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 26 U.S.C. § 9812; Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).

DOWNLOAD TEMPLATE
Patient Complaint to State Government Agency

b. Sample Provider Complaint to State Government Agency (Parity)

Tips For Providers Complaining To State Government Agencies (Parity)

- Send copies of supporting documents along with your complaint, including (where applicable): copies of denials/adverse benefit determinations by the plan; copies of the plan's and external review agent's determinations in any internal and external appeals; any materials that were submitted with appeals; clinical explanation of why the patient(s) needs the care at issue; plan documents showing that the plan limits or excludes MH/SUD care; copies of the plan's medical necessity criteria; copies of any requests you or your patient(s) made for information you are entitled to (like medical necessity criteria) and any responses received from the plan.
- Remember to include a release form, signed by your patient, permitting you to discuss his/her health information with the government agency.
- **If you are complaining to the NY Department of Financial Services (DFS)**, you should complete the DFS Complaint Form, available online, and submit the DFS Complaint Form together with your complaint based on this sample and your supporting documentation. You may submit the complaint online, by fax, or by mail. If you have any questions, you may call the DFS Consumer Assistance Unit at (800) 342-3736.
- **If you are complaining to the NY Department of Health (DOH)**, you should email the Sample Complaint and your supporting documentation to managedcarecomplaint@health.ny.gov.
- Legal Action Center is gathering information about possible parity violations in New York. If you (and, if applicable, your patient) are willing, please send us a copy of your complaint. We will keep your information confidential, and will only use the complaint for informational purposes. We will not be evaluating your complaint for possible representation. Please send the copy of your complaint either by email (send to lacinfo@lac.org with subject line "Parity Complaint"), fax (send to 212-675-0286; write ATTN: Parity Complaint), or mail (send to Parity Complaint, Legal Action Center, 225 Varick St. Suite 402, New York, NY 10014).

Sample Provider Complaint To State Government Agency (Parity)

[Print on Your Letterhead; If No Letterhead, Write Provider Name & Address]

[Date]

[Insurance Commissioner
New York Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Fax: (212) 480-6282]

[Medicaid Director
New York Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov]

Re: Possible Violation of Mental Health Parity & Addiction Equity Act

To Whom It May Concern:

I believe *[Insert Health Plan Name]* **may be violating the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (federal parity law).** *[**Optional:** I also believe [Insert Health Plan Name] may be violating [**Insert One or More as Appropriate**: [New York State law] [the Affordable Care Act]]*. **The federal government has delegated primary enforcement of the federal parity law to the State Insurance Commissioners and Medicaid Directors.**

The federal parity law requires health plans that offer mental health (MH) and substance use disorder (SUD) benefits to offer them at parity with other medical and surgical benefits. Specifically, the law: (1) forbids plans from having any separate financial requirements or treatment limitations that apply only to MH/SUD benefits; (2) forbids plans from applying financial requirements or treatment limitations to MH/SUD benefits that are more restrictive than the predominant ones that are applied to substantially all medical/surgical benefits; (3) requires plans to provide out-of-network benefits for MH/SUD services if it offers them for medical/surgical services; and (4) requires plans to disclose medical necessity criteria and other information upon request.[1] The Affordable Care Act (ACA) incorporates the federal parity law and includes additional protections for people seeking MH/SUD care.

I believe that *[Insert Health Plan Name]* **may be violating the federal parity law by:** *[**Insert All That Apply**]*

- **Not covering residential treatment for** *[substance use disorder and/or mental health]***.**
- **Not covering** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]***.**
- **Limiting coverage of** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]* **by** *[Insert Description of Limitation (e.g., by only covering up to one year of methadone treatment for addiction)]***.**
- **Only covering** *[#]* **of days of** *[substance use disorder and/or mental health] [outpatient / inpatient / residential]* **treatment per year.**
- **Only covering** *[#]* **of visits to** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **treatment per year.**
- **Charging higher co-payments for** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **than for comparable medical/surgical services.** *[**Suggested:** Include Information About the Co-Payment Being Charged for the MH/SUD Service and the Co-Payment Being Charged for Comparable Medical/Surgical Service(s).]*
- **Charging a separate deductible for** *[substance use disorder and/or mental health]* **services and for medical/surgical services.**
- **Limiting how much it will pay** *[per year / in my lifetime]* **for** *[substance use disorder and/or mental health]* **services.** *[**Suggested:** The plan will only pay [Insert Amount] [per year / in a beneficiary's lifetime]* **for** *[substance use disorder and/or mental health services.]*
- **Requiring patients to "fail first" at a lower level of care before approving a higher level of care.** *[**Suggested:** Explain Specifically What the Plan Is Doing (e.g., the plan will only approve inpatient treatment if patients fail first at outpatient treatment).]*
- **Refusing to cover** *[Insert MH/SUD Service]* **when patients did not complete an earlier course of treatment.**
- **Refusing to cover** *[Insert MH/SUD Service]* **when the plan says a patient is not improving.**
- **Requiring more frequent** *[pre-authorization / concurrent review]* **for** *[Insert MH/SUD Service]* **than for medical/surgical services.** *[**Suggested:** Explain Specifically What the Plan Is Doing (e.g., the plan is only approving one day of*

treatment at a time).]

- **Not having any** *[Insert Type of MH/SUD Provider]* **in its network.**
- **Refusing to provide information I am entitled to upon request.** *[**Suggested:** On [Date(s)] I requested [Insert Type of Information Requested, e.g., medical necessity criteria] but my plan refused to provide it.]*
- **Providing** *[insufficient and/or incorrect]* **information in denial letters.**
- **Applying medical necessity criteria more restrictively to MH/SUD benefits than to medical/surgical benefits.** *[**Suggested:** Explain In More Detail How Your Plan Is Applying Medical Necessity Criteria to the MH/SUD Benefit(s) You Requested.]*
- **Refusing to cover out-of-state** *[mental health and/or substance use disorder]* **services, although it covers out-of-state medical/surgical services.**
- **Applying unequal standards for provider admission to participate in-network to** *[mental health and/or substance use disorder]* **providers as compared to medical/surgical providers.**
- **Reimbursing** *[mental health and/or substance use disorder]* **providers at lower rates than medical/surgical providers.**
- **Using unequal methods for determining usual, customary, and reasonable charges for** *[mental health and/or substance use disorder]* **services as compared to medical/surgical services.**
- *[Insert Any Other Actions by the Plan That May Violate the Federal or State Parity Law(s), the ACA, and/or Other Laws.]*

[If You Have Seen the Health Plan Engage In This Conduct with Regard to Multiple Patients, Please Explain, Including As Much Detail As Possible.]

I respectfully request that you investigate whether *[Insert Health Plan Name]* **is violating the federal parity law, and whether it is violating provisions of the Affordable Care Act (ACA) that guarantee access to MH/SUD care.** ***[If patient's plan is protected by New York State law (see*** Section 6***):*** *Please also investigate whether [Insert Health Plan Name] is violating New York State law, including New York's parity law.]* **Please notify me in writing of your findings and any corrective action you take. If you need additional information, you can reach me at** *[Insert Phone # and/or Email Address and/or Address]***.**

Thank you for your assistance.

Sincerely,

[Name]
[Title]

*[**If You Are Including Supporting Documentation:** Enclosure]*

1. *See* 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 26 U.S.C. § 9812; Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68240 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).

DOWNLOAD TEMPLATE
Provider Complaint to State Government Agency

a. Sample Patient Complaint to Federal Government Agency (Parity)

Tips For Patients Complaining To Federal Government Agencies (Parity)

» Send copies of supporting documents along with your complaint, including (where applicable): a copy of your insurance card; copies of complaints made to State government agencies (DFS and/or DOH) and any responses you received to your complaints; copies of denials/adverse benefit determinations by the plan; copies of the plan's and external review agent's determinations in any internal and external appeals; any materials that were submitted with your appeals and complaints to State agencies; supporting information from your health care provider; plan documents showing that the plan limits or excludes MH/SUD care; copies of the plan's medical necessity criteria; copies of any requests you made for information you are entitled to (like medical necessity criteria) and any responses received from the plan.

» Make a copy of your complaint and any attachments, and keep them in a safe place.

» **If you are complaining to the U.S. Department of Labor (DOL),** you may submit an online complaint form (also available online as a printable mail-in form) and either paste your complaint based on this sample into the section titled "Other Information and Comments," or include your complaint based on this sample as an attachment. If you have questions, you may contact your regional office of DOL's Employee Benefits Security Administration. If you live in eastern New York, you may call (212) 607-8600 with questions. If you live in central or western New York, you may call (617) 565-9600 with questions. You may also call DOL at (866) 444-3272.

» **If you are complaining to the U.S. Department of Health & Human Services (HHS)**, you can email your complaint based on this sample and any supporting documentation to phig@cms.hhs.gov. If you have any questions, you can call HHS at (877) 267-2323.

» Legal Action Center is gathering information about possible parity violations in New York. If you are willing, please send us a copy of your complaint. We will keep your information confidential, and will only use the complaint for informational purposes. We will not be evaluating your complaint for possible representation. Please send the copy of your complaint either by email (send to lacinfo@lac.org with subject line "Parity Complaint"), fax (send to 212-675-0286; write ATTN: Parity Complaint), or mail (send to Parity Complaint, Legal Action Center, 225 Varick St. Suite 402, New York, NY 10014).

Sample Patient Complaint To Federal Government Agency (Parity)

[Date]

[Your Name]
[Your Address]

[CHOOSE APPROPRIATE FEDERAL GOVERNMENT AGENCY:]

*[**If You Live In Eastern NY:**]*
[U.S. Department of Labor – Employee Benefits Security Administration
New York Regional Office
33 Whitehall St, Suite 1200
New York, NY 10004
Fax (212) 607-8681]

*[**If You Live In Central or Western NY:**]*
[U.S. Department of Labor – Employee Benefits Security Administration
Boston Regional Office
JFK Federal Bldg
15 New Sudbury St, Room 575
Boston, MA 02203
Fax (617) 565-9666]

[U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Email: phig@cms.hhs.gov]

Re: Possible Violation of Mental Health Parity & Addiction Equity Act

To Whom It May Concern:

I believe my health plan, *[Insert Your Health Plan Name]***, may be violating the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (federal parity law).** *[**Optional:** I also believe my health plan may be violating the Affordable Care Act]***. I filed a complaint with** *[New York Department of Financial Services and/or New York Department of Health]* **on** *[Date]***. Enclosed is a copy of my complaint** *[**If Applicable:** and the response I received]***.**

The federal parity law requires health plans that offer mental health (MH) and substance use disorder (SUD) benefits to offer them at parity with other medical and surgical benefits. Specifically, the law: (1) forbids plans from having any separate financial requirements or treatment limitations that apply only to MH/SUD benefits; (2) forbids plans from applying financial requirements or treatment limitations to MH/SUD benefits that are more restrictive than the predominant ones that are applied to substantially all medical/surgical benefits; (3) requires plans to provide out-of-network benefits for MH/SUD services if it offers them for medical/surgical services; and (4) requires plans to disclose medical necessity criteria and other information upon request.[1] The Affordable Care Act (ACA) incorporates the federal parity law and includes additional protections for people seeking MH/SUD care.

I believe that *[Insert Your Health Plan Name]* **may be violating the federal parity law by:** *[**Insert All That Apply**]*

- **Not covering residential treatment for** *[substance use disorder and/or mental health]***.**
- **Not covering** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]***.**
- **Limiting coverage of** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]* **by** *[Insert Description of Limitation (e.g., by only covering up to one year of methadone treatment for addiction)]***.**
- **Only covering** *[#]* **of days of** *[substance use disorder and/or mental health] [outpatient / inpatient / residential]* **treatment per year.**
- **Only covering** *[#]* **of visits to** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **treatment per year.**
- **Charging higher co-payments for** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **than for comparable medical/surgical services.** *[**Suggested:** Include Information About the Co-Payment You Are Being Charged for the MH/SUD Service and the Co-Payment You Are Being Charged for Comparable Medical/Surgical Service(s).]*
- **Charging a separate deductible for** *[substance use disorder and/or mental health]* **services and for medical/surgical services.**
- **Limiting how much it will pay** *[per year / in my lifetime]* **for** *[substance use disorder and/or mental health]* **services.** *[**Suggested:** The plan will only pay [Insert Amount] [per year / in my lifetime]* **for** *[substance use disorder and/or mental health services.]*
- **Requiring me to "fail first" at a lower level of care before approving a**

Complaint Letter to Federal Government Agencies

higher level of care. *[**Suggested:** Explain Specifically What Your Plan Is Doing (e.g., the plan will only approve inpatient treatment if you fail first at outpatient treatment).]*

- **Refusing to cover** *[Insert MH/SUD Service]* **because I did not complete an earlier course of treatment.**
- **Refusing to cover** *[Insert MH/SUD Service]* **because the plan says I am not improving.**
- **Requiring more frequent** *[pre-authorization / concurrent review]* **for** *[Insert MH/SUD Service]* **than for medical/surgical services.** *[**Suggested:** Explain Specifically What Your Plan Is Doing (e.g., the plan is only approving one day of treatment at a time).]*
- **Not having any** *[Insert Type of MH/SUD Provider]* **in its network.**
- **Refusing to provide information I am entitled to upon request.** *[**Suggested:** On [Date(s)] I requested [Insert Type of Information Requested, e.g., medical necessity criteria] but my plan refused to provide it.]*
- **Providing** *[insufficient and/or incorrect]* **information in denial letters.**
- **Applying medical necessity criteria more restrictively to MH/SUD benefits than to medical/surgical benefits.** *[**Suggested:** Explain In More Detail How Your Plan Is Applying Medical Necessity Criteria to the MH/SUD Benefit(s) You Requested.]*
- **Refusing to cover out-of-state** *[mental health and/or substance use disorder]* **services, although it covers out-of-state medical/surgical services.**
- *[Insert Any Other Actions by Your Plan That May Violate the Federal Parity Law, the ACA, and/or Other Federal Laws.]*

I respectfully request that you investigate whether *[Insert Your Health Plan Name]* **is violating the federal parity law, and whether it is violating provisions of the ACA that guarantee access to MH/SUD care. Please notify me in writing of your findings and any corrective action you take. If you need additional information, you can reach me at** *[Insert Phone # and/or Email Address and/or Address]***.**

Thank you for your assistance.

Sincerely,

[Name]

*[**If You Are Including Supporting Documentation:** Enclosure]*

1. *See* 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 26 U.S.C. § 9812; Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68240 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).

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Patient Complaint To Federal Government Agency

b. Sample Provider Complaint to Federal Government Agency (Parity)

Tips For Providers Complaining To Federal Government Agencies (Parity)

» Send copies of supporting documents along with your complaint, including (where applicable): copies of complaints made to State government agencies (DFS and/or DOH) and any responses you received to your complaints; copies of denials/adverse benefit determinations by the plan; copies of the plan's and external review agent's determinations in any internal and external appeals; any materials that were submitted with appeals and complaints to State agencies; clinical explanation of why the patient(s) needs the care at issue; plan documents showing that the plan limits or excludes MH/SUD care; copies of the plan's medical necessity criteria; copies of any requests you or your patient(s) made for information you are entitled to (like medical necessity criteria) and any responses received from the plan.

» Make a copy of your complaint and any attachments, and keep them in a safe place.

» **If you are complaining to the U.S. Department of Labor (DOL),** you may submit an online complaint form (also available online as a printable mail-in form) and either paste your complaint based on this sample into the section titled "Other Information and Comments," or include your complaint based on this sample as an attachment. If you have questions, you may contact your regional office of DOL's Employee Benefits Security Administration. If you live in eastern New York, you may call (212) 607-8600 with questions. If you live in central or western New York, you may call (617) 565-9600 with questions. You may also call DOL at (866) 444-3272.

» **If you are complaining to the U.S. Department of Health & Human Services (HHS)**, you can email your complaint based on this sample and any supporting documentation to phig@cms.hhs.gov. If you have any questions, you can call HHS at (877) 267-2323.

» Legal Action Center is gathering information about possible parity violations in New York. If you are willing, please send us a copy of your complaint. We will keep your information confidential, and will only use the complaint for informational purposes. We will not be evaluating your complaint for possible representation. Please send the copy of your complaint either by email (send to lacinfo@lac.org with subject line "Parity Complaint"), fax (send to 212-675-0286; write ATTN: Parity Complaint), or mail (send to Parity Complaint, Legal Action Center, 225 Varick St. Suite 402, New York, NY 10014).

Sample Provider Complaint To Federal Government Agency (Parity)

[Print on Your Letterhead; If No Letterhead, Write Provider Name & Address]

[Date]

[CHOOSE APPROPRIATE FEDERAL GOVERNMENT AGENCY:]

*[**If You Live In Eastern NY:**]*
[U.S. Department of Labor – Employee Benefits Security Administration
New York Regional Office
33 Whitehall St, Suite 1200
New York, NY 10004
Fax (212) 607-8681]

*[**If You Live In Central or Western NY:**]*
[U.S. Department of Labor – Employee Benefits Security Administration
Boston Regional Office
JFK Federal Bldg
15 New Sudbury St, Room 575
Boston, MA 02203
Fax (617) 565-9666]

[U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Email: phig@cms.hhs.gov]

Re: Possible Violation of Mental Health Parity & Addiction Equity Act

To Whom It May Concern:

I believe *[Insert Health Plan Name]* **may be violating the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (federal parity law).** *[**Optional:** I also believe [Insert Health Plan Name] may be violating the Affordable Care Act]*. **I filed a complaint with** *[New York Department of Financial Services and/or New York Department of Health]* **on** *[Date]*. **Enclosed is a copy of my complaint** *[**If Applicable:** and the response I received]*.

The federal parity law requires health plans that offer mental health (MH) and substance use disorder (SUD) benefits to offer them at parity with other medical and surgical benefits. Specifically, the law: (1) forbids plans from having any separate financial requirements or treatment limitations that apply only to MH/SUD benefits; (2) forbids plans from applying financial requirements or treatment limitations to MH/SUD benefits that are more restrictive than the predominant ones that are applied to substantially all medical/surgical benefits; (3) requires plans to provide out-of-network benefits for MH/SUD services if it offers them for medical/surgical services; and (4) requires plans to disclose medical necessity criteria and other information upon request.[1] The Affordable Care Act (ACA) incorporates the federal parity law and includes additional protections for people seeking MH/SUD care.

I believe that *[Insert Health Plan Name]* **may be violating the federal parity law by:** *[**Insert All That Apply**]*

- **Not covering residential treatment for** *[substance use disorder and/or mental health]*.
- **Not covering** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]*.
- **Limiting coverage of** *[methadone for addiction treatment] [Suboxone / Subutex / Zubsolv / buprenorphine] [injectable naltrexone / Vivitrol] [oral naltrexone] [naloxone / Narcan]* **by** *[Insert Description of Limitation (e.g., by only covering up to one year of methadone treatment for addiction)]*.
- **Only covering** *[#]* **of days of** *[substance use disorder and/or mental health] [outpatient / inpatient / residential]* **treatment per year.**
- **Only covering** *[#]* **of visits to** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **treatment per year.**
- **Charging higher co-payments for** *[Insert Type of MH/SUD Provider (e.g., outpatient substance use disorder treatment)]* **than for comparable medical/surgical services.** *[**Suggested:** Include Information About the Co-Payment Being Charged for the MH/SUD Service and the Co-Payment Being Charged for Comparable Medical/Surgical Service(s).]*
- **Charging a separate deductible for** *[substance use disorder and/or mental health]* **services and for medical/surgical services.**
- **Limiting how much it will pay** *[per year / in my lifetime]* **for** *[substance use disorder and/or mental health]* **services.** *[**Suggested:** The plan will only pay [Insert Amount] [per year / in a beneficiary's lifetime]* **for** *[substance use disorder and/or mental health services.]*
- **Requiring patients to "fail first" at a lower level of care before approving a higher level of care.** *[**Suggested:** Explain Specifically What the Plan Is Doing (e.g., the plan will only approve inpatient treatment if patients fail first at outpatient treatment).]*

Complaint Letter to Federal Government Agencies

- » **Refusing to cover** *[Insert MH/SUD Service]* **when patients did not complete an earlier course of treatment.**
- » **Refusing to cover** *[Insert MH/SUD Service]* **when the plan says a patient is not improving.**
- » **Requiring more frequent** *[pre-authorization / concurrent review]* **for** *[Insert MH/SUD Service]* **than for medical/surgical services.** *[**Suggested:** Explain Specifically What the Plan Is Doing (e.g., the plan is only approving one day of treatment at a time).]*
- » **Not having any** *[Insert Type of MH/SUD Provider]* **in its network.**
- » **Refusing to provide information I am entitled to upon request.** *[**Suggested:** On [Date(s)] I requested [Insert Type of Information Requested, e.g., medical necessity criteria] but my plan refused to provide it.]*
- » **Providing** *[insufficient and/or incorrect]* **information in denial letters.**
- » **Applying medical necessity criteria more restrictively to MH/SUD benefits than to medical/surgical benefits.** *[**Suggested:** Explain In More Detail How Your Plan Is Applying Medical Necessity Criteria to the MH/SUD Benefit(s) You Requested.]*
- » **Refusing to cover out-of-state** *[mental health and/or substance use disorder]* **services, although it covers out-of-state medical/surgical services.**
- » **Applying unequal standards for provider admission to participate in-network to** *[mental health and/or substance use disorder]* **providers as compared to medical/surgical providers.**
- » **Reimbursing** *[mental health and/or substance use disorder]* **providers at lower rates than medical/surgical providers.**
- » **Using unequal methods for determining usual, customary, and reasonable charges for** *[mental health and/or substance use disorder]* **services as compared to medical/surgical services.**
- » *[Insert Any Other Actions by the Plan That May Violate the Federal Parity Law, the ACA, and/or Other Federal Laws.]*

I respectfully request that you investigate whether *[Insert Health Plan Name]* **is violating the federal parity law, and whether it is violating provisions of the ACA that guarantee access to MH/SUD care. Please notify me in writing of your findings and any corrective action you take. If you need additional information, you can reach me at** *[Insert Phone # and/or Email Address and/or Address]***.**

Thank you for your assistance.

Sincerely,
[Name]
[Title]

*[**If You Are Including Supporting Documentation:** Enclosure]*

1. *See* 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 26 U.S.C. § 9812; Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68240 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).

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Provider Complaint To Federal Government Agency

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