

NEW FEDERAL LAW MAY GIVE INSURED MARYLANDERS EASIER AND MORE AFFORDABLE ACCESS TO MENTAL HEALTH AND ADDICTION TREATMENT

Want to hear more about these rights and how to access them? Interested in a toolkit or presentation? Call the Maryland Parity Project at 410-235-1178 ext. 206 or visit www.MarylandParity.org

The Maryland Parity Project is a new initiative of the Mental Health Association of Maryland. The project aims to educate insured Marylanders and help them use these new rights to access mental health and addiction treatment under The Mental Health Parity and Addiction Equity Act of 2008. This new federal law requires equity in mental health/addiction and medical/surgical benefits offered by insurance companies. Project staff have developed and are distributing a tool kit, and a comprehensive website will be launched in Spring 2011.

In addition, project staff provides case assistance to consumers, providers and families who feel they are not receiving the benefits to which they are entitled. We are here to evaluate complaints and walk consumers and providers through the process of appealing an insurer's decision and if appropriate, assist in the filing a complaint with the proper government authority.

Here's how the law works: Insurers that offer mental health or addiction coverage must provide benefits on par with medical/surgical benefits. They cannot implement financial restrictions or treatment limitations that are more restrictive for mental health/addiction treatment than the predominant limitation or restriction applied to "substantially all" medical/surgical benefits.

To implement this new requirement, six categories of benefits have been established in federal regulations for all health care services in an insurance plan: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drugs. If the insurance plan offers mental health and addiction benefits in ANY of these areas, it must offer benefits in ALL of the areas where medical/surgical benefits are offered. The law does not require that insurers offer mental health or addiction coverage, but if offered, the above standards apply.

The no more restrictive requirements include both financial restrictions and treatment limitations. For example, if two-thirds of the medical/surgical benefits of a plan are subject to 20% co-insurance requirement, then mental health or addiction treatment benefits may NOT be subject to more than 20%.

The regulations also establish standards governing non quantifiable treatment limitations or NQTLs. These requirements prevent insurers from managing mental health care or psychiatric medications more stringently or creating more restrictive hurdles for providers seeking to participate on an insurance plan's provider panels or setting rates that are disproportionately lower for psychiatric care.

An important caveat is that not all commercially insured individuals are covered by the law. Currently only individuals insured through large employers (companies with 50 or more employees) or government are covered. Medicare is also specifically exempted in the law. Fortunately Maryland already has some protections in place for individuals not covered under this law: Maryland's parity law was enacted in 1993 and provides protections for people with individual and large employer policies that are comparable to the new federal parity standard. Small group policies in Maryland also have a required mental health benefit.

With different state and federal rules governing mental health coverage, understanding the system is complex for both individuals and providers. That's where the Maryland Parity Project comes in.

If you or your clients are not receiving proper treatment or reimbursement, please contact us. You can also request the parity toolkit or request a presentation for your organization by contacting Adrienne Ellis, Maryland Parity Project Director, 410-235-1178 ext. 206 or visit www.MarylandParity.org for more information.

Your Mental Health Coverage: Know Your Rights, Know Your Plan, Take Action

The Law

The Mental Health Parity and Addiction Equity Act aims to create equity in insurance coverage for mental health and addiction treatment. The law requires health insurers to place “no more restrictive” financial requirements or treatment limitations on mental health or addiction benefits than the “predominant” requirement or limitation that is applied to “substantially all” medical/surgical benefits. It also prohibits insurers from placing separate limitations or restrictions on mental health or addiction treatment. *(Terms are further explained at end of sheet)*

Your Rights

The law **does NOT require** that insurers offer mental health or addiction coverage, but instead requires that if an insurer offers ANY mental health or addiction benefits, they must be on par with medical/surgical benefits.

Under this law benefits are broken into six areas:

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

If the health plan has mental health or addiction benefits in ANY of the six areas, it must offer benefits in ALL of the areas where medical or surgical benefits are offered.

Plans may implement **no more restrictive financial requirements** on mental health or addiction treatment than medical/surgical treatment, including but not limited to: copays, deductibles, and annual limits.

Plans may implement **no more restrictive treatment limitations** on mental health or addiction treatment than medical/surgical treatment, including but not limited to: visit limitations, prior authorization, inpatient treatment, medication management and utilization review practices.

Your Plan

Not all health insurance plans are covered under the federal law. Some plans are covered under state laws, and some plans are exempted from the applicable laws, including small group, Medicare, Tricare, and Department of Defense plans.

Employer	Applicable Law	Regulatory Agency
Large Employer Fully-insured (51+ employees)	Federal and Maryland Parity Laws	Maryland Insurance Administration and/or US Department of Labor
Large Employer Self-insured (51+ employees)	Federal Parity Law	US Department of Labor
Small Employer (2-50 employees)	No Parity law applies, <i>but</i> Maryland Comprehensive Standard Benefit Plan applies	Maryland Insurance Administration
Individual or Self-employed	Maryland Parity Law	Maryland Insurance Administration
Federal, State or Local Government	Federal Parity Law unless an exemption was granted. <i>Approved exemptions can be found at http://www.cms.gov/SelfFundedNonFedGovPlans/</i>	US Office of Personnel Management and/or US Department of Labor

Your Mental Health Coverage: Know Your Rights, Know Your Plan, Take Action

Take Action

Know Your Plan Details

Your plan details will be outlined in your benefits book. You may need to speak with your benefits representative to understand your plan type (small group, large group, self-insured or fully-insured) as well as your plan benefits to see if you are covered under parity law.

Know Your Rights

Some of your new rights under the law include

- Right to a written reason for denial of treatment
- Right to appeal your insurer's decision both through internal, and if necessary, external review

Talk With Your Provider

He or she can help with your appeal process to ensure you get the appropriate treatment. Your provider may get information from your insurer before you do, including reason for denial and steps to take to file an appeal.

Contact Your Insurer

It is important to understand the reason for denial. It is how violations are determined. If you choose to file an appeal of the denial, you will need to understand your insurer's appeal process.

Contact the Corresponding Government Agency

The government agency that has oversight over your plan varies depending on how you are insured. You may file an appeal with the government agencies noted in the chart on the front page of this fact sheet after you have exhausted your insurer's internal appeals process.

Seek Help

For questions or for help in filing an appeal contact the **Maryland Parity Project at 410-235-1178 ext. 206** or www.marylandparity.org

RESOURCES

Maryland Parity Project
www.MarylandParity.org

Maryland Insurance Administration
www.mdinsurance.state.md.us/sa/jsp/Mia.jsp

Maryland Attorney General's Office Health Education Advocacy Unit
www.oag.state.md.us/consumer/HEAU.htm

US Department of Labor
www.dol.gov/ebsa

US Office of Personal Management
www.opm.gov/insure/federal_employ/index.asp

National Parity Coalition
www.mentalhealthparitywatch.org

Term	Definition	Example
Substantially All	The regulations define substantially all as 2/3 of the benefits in one of the six categories of benefits.	A plan may not implement visit limitations for all mental health or addiction inpatient treatment if it only limits orthopedic inpatient treatment on the medical/surgical side.
Predominant requirement or limitation	A requirement or limitation must be applied to 50% of medical/surgical spending in a category to be considered predominant. Requirements or limitations for one medical/surgical benefit in a category do not qualify as predominant.	If 50% of the inpatient, in-network medical/surgical benefits are subject to a 20% co-insurance requirement, then inpatient, in-network mental health/addiction benefits cannot be subject to more than 20%.

What Benefits Am I Entitled To?

EMPLOYER	APPLICABLE LAW	BENEFITS	APPEALS
Large Employer Fully insured <i>(51+ employees)</i>	Federal Parity and Maryland Parity Law	Federal Parity Requires: Any Mental Health/Addiction Benefits offered must be on-par with medical/surgical benefits in 6 categories: Inpatient, in-network Outpatient, in-network Inpatient, out-of-network Outpatient, out-of-network Emergency services Prescription drugs	Maryland Insurance Administration and/or US Department of Labor
	Maryland Parity applies ONLY if it is more beneficial to the consumer than the Federal Parity standard.	Maryland Parity Requires Plans include <ul style="list-style-type: none"> At least the same number of days for mental health and addiction inpatient care covered under the plan for medical or surgical care, including residential crisis services At least 60 days for partial hospitalization Insurance Coverage for Outpatient Visits <ul style="list-style-type: none"> 80% for first 5 visits in a calendar year 65% for the 6th through 30th visit in a calendar year 50% for the 31st and subsequent visits in a calendar year 	
		Both Federal and Maryland Parity Laws Require <ul style="list-style-type: none"> No discrimination in cost-sharing No separate deductible, lifetime limit or annual out-of-pocket limits 	
Large Employer Self insured <i>(51+ employees)</i>	Federal Parity	Any Mental Health/Addiction Benefits offered must be on-par with medical/surgical benefits in 6 categories: Inpatient, in-network Outpatient, in-network Inpatient, out-of-network Outpatient, out-of-network Emergency services Prescription drugs <ul style="list-style-type: none"> No discrimination in cost-sharing No separate deductible, lifetime limit, or annual out-of-pocket limits 	US Department of Labor
Small Employer <i>(2-50 employees)</i>	No Parity Law applies BUT Maryland Comprehensive State Benefit Plan	Maryland Comprehensive Standard Benefit Plan includes <ul style="list-style-type: none"> Detoxification in a hospital or related setting Residential services up to 60 days in hospital, licensed program, or residential crisis services Two days partial hospitalization may be substituted for one inpatient day Unlimited outpatient visits In-network cost-sharing for each service 70% insurer/30% patient Out-of-network cost-sharing for each service 50% insurer/50% patient 	Maryland Insurance Administration

What Benefits Am I Entitled To?

EMPLOYER	APPLICABLE LAW	BENEFITS	APPEALS						
<p style="text-align: center;">Individual or Self-Employed</p>	<p style="text-align: center;">Maryland Parity Law</p>	<p>Plans must include</p> <ul style="list-style-type: none"> • No discrimination in cost-sharing, except outpatient (see below) • No separate deductible, lifetime, or annual out-of-pocket limits • At least the same number of days for mental health/addiction inpatient care that are covered for medical/surgical care, including residential crisis services • At least 60 days for partial hospitalization • Insurance Coverage of Outpatient Visits <ul style="list-style-type: none"> • 80% for first 5 visits in a calendar year • 65% for the 6th through 30th visit in a calendar year • 50% for the 31st and subsequent visits in a calendar year 	<p style="text-align: center;">Maryland Insurance Administration</p>						
<p style="text-align: center;">Federal Government</p>	<p style="text-align: center;">Federal Parity Law</p>	<p>Any Mental Health/Addiction Benefits offered must be on-par with medical/surgical benefits in 6 categories:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Inpatient, in-network</td> <td style="width: 50%;">Outpatient, in-network</td> </tr> <tr> <td>Inpatient, out-of-network</td> <td>Outpatient, out-of-network</td> </tr> <tr> <td>Emergency services</td> <td>Prescription drugs</td> </tr> </table> <ul style="list-style-type: none"> • No discrimination in cost-sharing • No separate deductible, lifetime limit, or annual out-of-pocket limits <p>Federal Employee Health Benefit Plan has had parity since 2001 based on President Clinton’s Executive Order in 1999.</p> <p><i>Certain federal employee plans, including DOD and Tricare benefit plans are exempt from 2008 Federal Parity Law.</i></p>	Inpatient, in-network	Outpatient, in-network	Inpatient, out-of-network	Outpatient, out-of-network	Emergency services	Prescription drugs	<p style="text-align: center;">US Office of Personnel Management</p>
Inpatient, in-network	Outpatient, in-network								
Inpatient, out-of-network	Outpatient, out-of-network								
Emergency services	Prescription drugs								
<p style="text-align: center;">State and Local Government</p>	<p style="text-align: center;">Federal Parity Law</p>	<p>Any Mental Health/Addiction Benefits offered must be on-par with medical/surgical benefits in 6 categories:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">In-network, inpatient</td> <td style="width: 50%;">In-network, outpatient</td> </tr> <tr> <td>Out-of-network, inpatient</td> <td>Out-of-network, outpatient</td> </tr> <tr> <td>Emergency services</td> <td>Prescription drugs</td> </tr> </table> <ul style="list-style-type: none"> • No discrimination in cost-sharing • No separate deductible, lifetime limit, or annual out-of-pocket limits <p>State and local governments may request an exemption. <i>Approved exemptions can be found at: http://www.cms.gov/SelfFundedNonFedGovPlans/</i></p>	In-network, inpatient	In-network, outpatient	Out-of-network, inpatient	Out-of-network, outpatient	Emergency services	Prescription drugs	<p style="text-align: center;">US Department of Labor or Department of Health and Human Services</p>
In-network, inpatient	In-network, outpatient								
Out-of-network, inpatient	Out-of-network, outpatient								
Emergency services	Prescription drugs								

Are My Rights Being Violated?

The Parity Standard

The new federal parity law requires health insurers of parity covered plans (see *Maryland Parity Project Benefits Chart* for more information) that offer mental health or addiction benefits to ensure financial requirements and treatment limitations for mental health and addiction treatment are no more restrictive than predominant requirements or limitations that are applied to substantially all medical/surgical benefits. Plans may not implement separate limitations or requirements for mental health or addiction treatment (see *Maryland Parity Project Parity Overview* for further explanation).

Parity Violation Example

In 2010 Blue Cross Blue Shield of Illinois established a new policy requiring prior authorization of all outpatient mental health visits. They believed that because they had removed quantitative visit limits they were in compliance with the federal parity law. Provider and advocacy groups opposed this new policy, which they cited as a federal parity violation because a nonquantitative treatment limitation had been established requiring prior authorization for behavioral health care which was not applied by the insurer to medical/surgical treatment. In response to these complaints, BCBS of Illinois reversed their decision and removed the prior authorization requirement for outpatient mental health visits.

Treatment Limitations That May Violate the Parity Law

Below are examples of treatment limitations used in managed care that may be no more stringently applied to mental health and substance use disorder treatment than to medical/surgical treatment.

- Refusal to Pay for Specific Types of Behavioral Health Treatment
- Determination of Medical Necessity
- Utilization Review
 - Prior authorization
 - Concurrent review
 - Retrospective review
- Prescription Drug Coverage
 - Fail first requirements
- Provider Panel Restrictions
- Discrimination in Reimbursement Practices
- Coinsurance Requirements
- Visit Limitations

If it Seems Unfair, Ask Questions!

- Ask your provider
- Ask your insurer
- Call the Maryland Parity Project 410-235-1178 ext. 206

Check www.MarylandParity.org for updated examples and actual complaints.

How to File a Complaint

TAKE ACTION

Step One: Know Your Plan - Your rights and benefits depend on how you are insured. If you get insurance through your employer, the laws governing your plan differ depending on whether your employer is large (51+ employees) or small (2-50 employees). Rules are different for individual policies and government plans. If you don't know your plan type and get insurance through your employer, ask your benefits representative, usually the Human Resources or Personnel departments. You can also call the number on your insurance card.

What Does Self Insured Mean? To further complicate things, if you are insured by a large employer, there's one more hoop to go through. You need to know whether your employer is "self insured" or not. Normally an employer buys insurance and pays a monthly premium for your coverage (you may pay a portion of that monthly fee through payroll deduction). The insurance company pays all of the medical bills for insured employees. If employees have a large amount of medical bills that exceed the total of the monthly premiums collected by the insurance company, the insurer is "at risk" and eats the difference. Some large companies prefer to hold the risk themselves and contract with insurance companies only to administer their insurance plan (i.e. handling enrollment and paying health care providers for services rendered, with the company's money). This is referred to as a self insured plan. Your benefits representative will also know if your plan is self or fully insured.

Step Two: Obtain Written Reason for Denial - If you have been denied coverage or treatment, you have the right to request a document from your insurer, free of charge and in a timely manner, which states the reason for denial.

Step Three: Ask For Help - Your provider can help with appeals to your insurer. He or she is often the first to receive billing information, including denials from insurers. He or she may have information you need in order to continue the process. **You can also call the Maryland Parity Project at 410-235-1178 ext. 206 or visit online at www.MarylandParity.org**

Step Four: Gather Materials - The things listed below may be useful to you if you continue through the appeal process.

- **Explanation of Benefits Booklet**- This may outline the appeals process. If you don't have a copy, you can request one from your insurance company or from your insurance representative at your employer. It can sometimes be found online as well.
- **Definition of Medically Necessary** - The insurance company must provide you with written criteria for the determination of medical necessity for your treatment. (The toolkit includes sample letters you may find useful.)
- **Reason for Denial of Treatment or Reimbursement** - This must be given to you in a timely manner free of charge. (The parity project toolkit includes sample letters you may find useful.)
- **Letter Explaining Necessity of Prescribed Treatment** - Request this from your provider that prescribed the treatment.

Step Four continued: *More documentation* you may find useful.

- **Good Notes** - Document all calls and conversations you have regarding this appeal. Keep track of names and dates of all conversations.
- **Understanding the Process** - If you are unsure of the appeal process, check your benefits book, ask your insurance company, or seek help from your benefits rep at your employer.
- **Medical Bills and Tracking of Visits** - Keep copies of bills and records of visits for treatment.

Step Five: *File an Appeal* - with your insurer. Make sure to do this within the time allotted. If you are unsure of the process or deadlines, call your insurer or your benefits rep at your employer or call the Maryland Parity Project 410-235-1178 ext. 206.

Step Six: *Exhaust Internal Appeals Processes* - Different insurance companies may have different internal appeal processes. Be sure to follow this process and meet all required deadlines. Often if the first appeal is denied, the next level of appeal will be outlined in the denial letter.

Step Seven: *File a Complaint* - for an independent review of the denial. In the complaint be sure to reference the federal parity law and any potential violations. Most complaints are filed with the Maryland Insurance Administration (MIA). The following are exceptions:

- Complaints for large employer, self insured plans and complaints for state and local government plans are filed with the US Department of Labor
- Complaints for federal government plans are filed with the US Office of Personnel Management

See the benefits chart in the parity project toolkit or view online at www.MarylandParity.org for more information. The toolkit also contains sample complaint letters you may find useful. If you choose to file a complaint, consider working with the Maryland Parity Project to do so or send us a copy of the filed complaint.

Step Eight: *Ask for a Hearing* - If your complaint is under the jurisdiction of the Maryland Insurance Administration and MIA upholds the decision of the insurer, you are entitled to a hearing. The details and timelines of how to request this will be outlined in the MIA decision letter.

In Addition: *Advocate for Parity* - If you received no satisfactory recourse, or you simply felt the process was too difficult, consider working for better mental health laws and oversight. Call the Maryland Parity Project 410-235-1178 ext. 206 or write a letter to your Federal or State elected officials.

Appeal of Denial of a Claim and Information Request

[Date]

[insert name of insurance company and/or managed behavioral health company]

[member services department or other applicable dept.]

[insert address]

Re: [insert patient name, insurer, ID# and group #]

Dear [member services or other applicable dept]

I am writing to appeal [insurer name] decision to deny coverage for [state name of treatment denied]. It is my understanding based on your letter of denial dated [insert date] that this [insert treatment] has been denied because [quote specific reason in denial letter if received].

I have been a member of your plan since [date]. I have paid for this benefit and [insert name of provider] is licensed by the state of Maryland and accredited to provide these treatment services. I have enclosed a letter from [provider] explaining why [he/she] recommends [treatment or service] and [his/her] qualifications. I am in dire need of these treatment services, and they are covered by my benefit plan and should be paid for.

I believe I am entitled to this service under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity* law, which requires that insurers implement no more restrictive financial requirements or treatment limitations for mental health/substance abuse treatment than predominate requirements or limitations for substantially all medical/surgical benefits.

Also, I hereby request a copy of the medical necessity criteria and specific reasons for denial that you are relying on in denying reimbursement for my treatment at the following level of care:

outpatient inpatient emergency care
 residential partial hospitalization prescription drugs
 intensive outpatient other

I request that you immediately remit the medical necessity criteria and specific reasons for denial that you rely on in reaching a different medical decision than my treating physician and refusing to cover my treatment services. **You may [fax, email, mail] the medical necessity criteria and specific reasons for denial to my attention at [insert contact].** Should you require additional information, please do not hesitate to contact me at [insert phone number]. I look forward to hearing from you in the near future.

Sincerely

[name]

Insurance Appeal Note Taking Form

Keep this form with your copies of bills, treatment records, and other documents relating to this appeal. You may make copies of this form as needed.

Insurer _____ Insurer contact number: _____

ID # _____ Insurer contact name: _____

Group # _____

Treatment description: _____

Date of treatment: _____

Reason for denial: _____

Date denial received: _____

Date appeal filed: _____

Conversation:

Date: _____

Name of contact: _____

NOTES:

Follow-up required:

Follow-up date: _____

Conversation:

Date: _____

Name of contact: _____

NOTES:

Follow-up required:

Follow-up date: _____

Health Insurance Glossary

These definitions may be useful to you in your navigation through the insurance appeals process.

Appeal Process: The way in which a consumer can fight a denied insurance claim. Usually each insurer has its own process with specific steps, requirements and deadlines.

Behavioral Health: Refers to study, assessment, diagnosis, treatment and prevention of mental illness and substance use disorders.

Classifications of benefits: To create a framework for implementation of the federal parity law, the parity regulations established 6 different categories of benefits within which all mental health addition and somatic services must be classified: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drugs.

Coinsurance or Copayment: Refers to money that an insured individual is required to pay for services, after any applicable deductible has been met. Coinsurance is generally specified by a percentage or flat amount. For example, the individual may either be required to pay a flat amount of \$20 per outpatient visit or 20 % toward the charges and the plan pays the remaining amount.

Deductible: A specific dollar amount required by some health insurance plans that insured individuals must pay annually out-of-pocket before the plan begins to make payments for claims. The federal parity law prevents health plans from implementing a deductible for mental health or addiction treatment that is separate from the overall plan deductible.

ERISA: The federal Employee Retirement Income Security Act of 1974 established minimum standards for pension and health benefit plans offered by large employers. Additionally ERISA preempted state laws governing health insurance for employers who choose to self insure (employers who pay all of the claims for their employees' health care with their own funds rather than contracting with an insurance company to do so). Self-funded health insurance plans are often referred to as ERISA plans.

External Review: One of the final steps in the appeal process. A consumer may request an external review once they have exhausted the insurance company's internal review process. Usually an independent panel or government agency will review the documentation to determine whether or not the insurance company should pay for the treatment provided.

Fail First Protocol: A medical management strategy used to reduce health care costs, which is also referred to as step therapy. An insurance company will require the individual to try and fail at a less expensive treatment before they will pay for a more expensive treatment, for example, requiring that an individual try and not succeed with a generic medication before coverage of a brand name medication is provided.

Fully-Insured: In a traditional employer-offered, fully insured health plan, the company pays a fixed monthly premium for a year per participant, and participating employees may be required to pay a portion of that premium, typically through payroll deduction. The insurance company pays all of the medical claims for covered employees. This is often referred to as "holding the risk" because if claims for the year exceed the total amount of collected premiums, the insurance company absorbs this loss.

Generic Drug: A prescription drug which is basically the same as a brand name prescription drug, but which can be produced by other manufacturers after the brand name drug's patent has expired. Generic drugs are usually less expensive than brand name drugs.

In-network: Providers and/or health care facilities that have been accepted to participate in a health plan's network. Insured individuals usually pay less when using an in-network provider because in-network providers have agreed to fixed payment rates and deliver services at lower cost to the insurance companies with which they have contracts.

Inpatient: Services delivered in a hospital for at least 24 hours.

Large Group: Generally, these are businesses with more than 50 employees. The laws governing health insurance to large employer groups are different than those for small employer groups. Large employer groups are regulated under the parity law and must meet the federal parity standard.

Medical Necessity: Criteria used by health insurance companies to determine if health care services should be covered. A medical service is generally considered to meet medical necessity criteria when it is consistent with general standards of medical care, consistent with a patient's diagnosis, and the least expensive option available to provide a desired health outcome.

No More Restrictive: As specified by the federal parity regulations, if a limit or requirement is applied to substantially all benefits, and it is the predominant level of restriction, this limit or requirement can be applied no more restrictively to mental health/addiction benefits than to medical/surgical benefits. For Example, a plan may not require concurrent review for inpatient, in-network mental health and addiction benefits, if it uses retrospective review for all inpatient, in-network medical/surgical benefits. (See utilization review for more information.)

Non-Quantitative Treatment Limitation: A limitation that cannot be expressed numerically. Examples of these cost containment strategies include care management, utilization review, prior authorization, step-therapy, prescription drug formularies, etc.

Out-of-network: Providers and/or health care facilities that are not participants in a health care plan and as a result are free to set their own rates for services rendered. Insurance plans may choose to partially cover services delivered out-of-network or they may exclude reimbursement entirely.

Out-of-Pocket: Health care costs for which the insured individual is responsible, due to deductibles, coinsurance or copayments or lack of plan coverage for a service.

Parity: The quality or state of being equal. Behavioral health parity is the recognition of mental health conditions and addictions as equivalent to, or on par with physical illnesses.

Partial Hospitalization: Services performed in a hospital setting as an alternative to an inpatient stay. Sometimes these services are provided as a follow-up once a patient has been released from an inpatient stay.

Predominant: The parity regulations define "predominant" as a requirement or limit applied to more than half of medical/surgical benefits in a category. For example, if more than half of the inpatient, in-network medical/surgical benefits are subject to a 20% coinsurance requirement, then inpatient, in-network mental health/addiction benefits **cannot** be subject to a coinsurance requirement that is more than 20%.

Prescription Drug Formulary: A list of prescription medications selected for coverage under a health insurance plan based upon their efficacy, safety and cost effectiveness. Some health insurance plans may require that patients obtain prior authorization before non-formulary (non-preferred) drugs are covered or require that a patient pay a greater share or all of the cost involved in obtaining a non-formulary prescription.

Prior Authorization or Pre Certification: Refers to the process by which a patient is pre-approved for coverage of a specific treatment or prescription drug. Health insurance companies may require that patients meet certain criteria before they will extend coverage for specific treatments or medications. In order to pre-approve such a drug or service, the insurance company will generally require that the patient's provider submit notes and/or lab results documenting the patient's condition and treatment history.

Provider Panel: A group of healthcare professionals with whom an insurance company has contracted to provide services. These providers serve as the in-network providers and are often contracted at a reduced rate.

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

Self-Insured: An employer who pays for employee health care claims is referred to as self-insured (as opposed to fully-insured employers who contract with an insurance company that is responsible for or "holds the risk for" payment of employee health care claims). It is often difficult for individuals to determine whether their employer is self-insured because many self-insured companies contract with insurance companies only to administer their insurance plan (i.e. handling enrollment and paying providers for services rendered with the company's money).

Small Group: The market for health insurance coverage offered to small businesses - those with between 2 and 50 employees in most states. These health benefit plans are not currently regulated under the federal parity law and are exempt from the federal parity standard.

Somatic Care: Affecting the body rather than the mind, often referred to as medical/surgical care.

Standard of Care: A clinically recognized, diagnostic and treatment process that a provider should follow for a patient, illness or clinical circumstance. This criterion is often used in determining the medical necessity of a specific treatment.

Substantially All: The parity regulations define "substantially all" as 2/3 of the benefits in one of the six classifications of benefits within which all health care services must be categorized. For example, a plan may not impose day limits for mental health/addiction inpatient treatment if it only imposes such limits for a single medical/surgical treatment in the inpatient category, such as orthopedic inpatient treatment.

Usual, Customary and Reasonable (UCR) Charge: The term is often used by medical plans in justifying the amount of money they will pay for specific health care services. The Health Insurance Association of America conducts periodic surveys of provider fees, but each insurer has its own procedure for determining UCR payments.

Utilization Review: The process used by insurers to determine if a patient's use of health care services was medically necessary, appropriate and within the guidelines of standard medical practice. Utilization review may also be referred to as medical review or utilization management. There are three types of utilization review:

- **Concurrent:** Concurrent utilization review takes place **during** the treatment. It is often used for outpatient mental health treatment. Federal regulations deem concurrent utilization review as more restrictive than retrospective review, but less restrictive than prior utilization review.
- **Prior:** Prior utilization review is often referred to as prior authorization or precertification. This type of review takes place **before** the treatment is rendered. The federal parity regulations consider this type of utilization review the most restrictive type.
- **Retrospective:** This type of review takes place **after** the treatment or services have been given. It is often used for outpatient somatic care. According to the federal parity regulations, retrospective review of treatment is considered the least restrictive of the three types.

Resources

Maryland Resources

Maryland Parity Project

For more information about mental health and addictions parity or for help with your insurance coverage of mental health and addiction treatment.

<http://www.MarylandParity.org>

Drug Policy Clinic – University of Maryland School of Law

The Drug Policy Clinic represents individuals who face discrimination based on their history of alcoholism or drug dependence and advocates for the expansion of addiction treatment. The Clinic will assist addiction treatment providers and their patients identify and challenge violations and has developed the *Provider Parity Resource Guide* to help providers understand and enforce the Parity Act.

Contact Ellen Weber, Director of the Drug Policy Clinic, for more information or copies of the *Provider Parity Resource Guide*. eweber@law.umaryland.edu or 410-706-0590.

Maryland Attorney General Health Education and Advocacy Unit

For information on legal help filing an appeal with your insurer

www.oag.state.md.us/consumer/HEAU.htm

Maryland Insurance Administration

For more information on filing a claim with Maryland Insurance Administration

<http://www.mdinsurance.state.md.us/sa/jsp/consumer/FileComplaint.jsp>

Finding your elected officials

www.mdelect.net

Federal Resources

National Parity Implementation Coalition

The coalition members have worked for years to pass federal parity legislation and are now monitoring the implementation of the law. Members will answer questions and are collecting data on appeals filed.

Phone: 866-882-6227 www.mentalhealthparitywatch.org

US Department of Labor

For information on how to file a federal claim

http://www.dol.gov/ebsa/publications/how_to_file_claim.html

US Office of Personnel Management

For more information on Federal Employee Health Benefit Plans

<http://www.opm.gov/insure/health/index.asp>

US Department of Health and Human Services Centers for Medicare/Medicaid Services

For more information on filing a claim on a fully-insured plan Helpline: 877-267-2323

http://www.cms.gov/HealthInsReformforConsume/04_TheMentalHealthParityAct.asp#TopOfPage

Federal Register

To see the full text of the Interim Final Regulations

<http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>

Have Health Insurance but Still Have Difficulty Accessing Mental Health Treatment?

If you have health insurance that offers mental health or addiction treatment, a new federal law may have given you more rights in accessing care. Not all plans are covered by the new law, but for those that are, treatment limitations and costs must be no more restrictive than your medical or surgical care. If you have been denied treatment in the past or have paid more for mental health or addiction treatment, you may want to check to see if your plan is covered. To find out more visit the Maryland Parity Project website at www.MarylandParity.org.

Have Health Insurance But



Have to pay a separate and/or higher co-payment for mental health or addiction services?



Have to pay a separate and/or higher deductible for mental health or addiction services?



Have a limit on the number of visits you make to your mental health or addiction treatment provider?



Have a requirement that your provider must periodically review your treatment with your insurance company?



Have been denied coverage for residential or inpatient treatment for mental health or addiction treatment?

**Need Help?
Want More
Information?**

Maryland Parity Project

410.235.1178 ext. 206

www.MarylandParity.org