Fairness in Mental Health and Substance Use Insurance Coverage

TOOLKIT

December 2021

Parity Overview

What is parity?

Parity means 'at the same level'. Mental health and addiction treatment parity requires health insurance plans to cover mental health and substance abuse treatment at the same level as other types of medical care.

Why is parity important?

Health insurance should help millions of Americans get the mental health or addiction treatment they need, yet too many health plan members face lower visit limits, higher out of pocket costs and stricter rules on how care is reviewed than for medical and surgical benefits.

Federal Parity Laws

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

MHPAEA applies to large group and self-insured health plans and Medicaid managed care plans. MHPAEA does not *require* health plans to provide mental health or addiction benefits, but *if* they do, treatment limits and out of pocket costs must be at the same level as medical and surgical care.

The Patient Protection and Affordable Care Act of 2010 (ACA)

The ACA strengthens coverage for mental health and addiction through:

- **Consumer protections:** Health plans can't turn people down or charge more for having major illnesses such as mental health or substance use conditions. The law does not allow lifetime or annual treatment limits. Parents can include adult children on their health plan up to age 26.
- **Medicaid expansion:** States have the choice to expand Medicaid eligibility to any household with an income at or below 138% of the federal poverty level ($16,400/year for one person).
- **Health insurance exchange:** Every state must have a state or federally run health insurance exchange with health plans that meet certain standards. Exchange plan premiums are partly covered by up-front tax credits up to 400% of the federal poverty level ($97,200 for one person).
- **Parity in individual and small group plans:** Requires all individual and small group health plans to meet MHPAEA parity requirements whether or not they are sold through an exchange. Requires parity in private health plans that cover people in Medicaid expansion and Children's Health Insurance Plans (CHIP).
- **Essential Health Benefits:** All individual and small group plans must cover 10 Essential Health Benefits (EHB). *Behavioral health* is one EHB category. EHBs must meet parity standards, not only within the 'behavioral health' category, but also in other categories such as emergency care.

The 21st Century Cures Act of 2016

The parity section of this law requires the U.S. Department of Health and Human Services to:

- Issue new guidance on how to comply with federal parity laws
- Hold a public meeting on how state and federal agencies must work together on parity
- Publish a report on federal parity investigations - issued each year for five years.

The Government Accountability Office (a federal watchdog) will study enforcement of federal parity law.

Tennessee Public Chapter 1012 (2018)

Passed by Tennessee lawmakers, this bill aligns state law with the Federal Parity Law and requires the state Department of Commerce & Insurance to issue a report to lawmakers on its efforts to enforce parity laws.

Consolidated Appropriations Act (2020)

Congress passed this act amending the Federal Parity Law. Insurers and health plans are required to prove that they comply with the existing parts of the law, file annual reports, and give that proof to regulators (either the U.S. Department of Labor or the Department of Health & Human Services, depending on the plan type) upon request.

Tennessee Public Chapter 244 (2021)

Building on the Consolidated Appropriations Act, lawmakers in Tennessee passed legislation requiring the state Department of Commerce & Insurance to obtain reports filed with federal regulators by Tennessee health plans and provide them annually to the Tennessee Legislature.

Consumers in Tennessee will now be able to see how well their plan complies with federal parity law.

Health Plans and Federal Parity

Not all types of health coverage must meet parity requirements, and conditions under which parity applies vary. The following chart shows the types of health plans that must comply with federal parity law and the conditions that apply.

Type of Plan	Parity?	Notes
Employer Sponsored		
Large employer > 50 employees	Yes	Not required to provide mental health or addiction benefits, but if they do, coverage must be on par with other medical benefits.
Small employer 2 to 50 employees	Depends	*If created after 3/23/2010,* must provide mental health benefits. Required to follow federal parity law.

Federal Employee Health Benefits Plan (FEHBP)	**Yes**	Must provide mental health benefits; required to follow federal parity law.[1]
Non-federal government	**No**	Some health plans for state or local government workers can opt out of federal parity law.
Faith-based organizations	**No**	Plans for employees of faith-based organizations can opt out of federal parity law.
Retiree only	**No**	Plans that only cover retirees can opt out of federal parity law.
Government Programs		
Medicare	**No**	Federal health plan for people who are age 65 or older and people with disabilities. Federal parity law does not apply.
Children's Health Insurance Program (CHIP)	**Yes**	Government health plan for low to middle income children. Federal parity law applies.
Medicaid	**Depends**	Government health plan for certain low-income children and adults.[2] Federal parity law applies to Medicaid managed care plans, but not Medicaid Fee-for-Service (FFS) plans.
TRICARE	**No**	Federal health care program for uniformed military service members and their families
Individual Plans		
Individual health plans (You buy for self or family)	**Depends**	*If created after 3/23/2010 or changed since,* must provide mental health benefits; required to follow federal parity law.

Parity Protections

Federal parity law protects health plan members by requiring the same level of coverage for mental health and addiction treatment as for other types of medical and surgical care.

Types of care:

- Hospital or residential treatment
- Outpatient visits
- Emergency or crisis care
- Prescription drugs
- Both in-network and out-of-network

Out-of-Pocket Costs: Costs for mental health or addiction treatment must not be greater

[1] U.S. Office of Personnel Management, FEHB Program Carrier Letter, No. 2008-17 (November 10, 2008), https://www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf

[2] Federal law restricts the use of Medicaid dollars for service to adults between the ages of 21 and 64 in certain types of free standing psychiatric hospitals and residential facilities. 42 U.S.C. 1369(d).

than costs for most other medical care

- Co-pays: Flat fee per visit or service
- Co-insurance: Percentage of total service cost
- Maximum out-of-pocket costs: What you pay before the plan pays 100%
- Deductibles: What you pay before the plan begins to pay
- Annual or lifetime dollar limits: The most a plan will pay in a year or lifetime

Treatment limits: The number of visits or days for mental health or addiction treatment must be no less than limits for most other medical care

- Number of outpatient visits
- Number of days in hospital or residential care
- Limits on prescription medications
- Excluded types of treatment or situations

Other limits: Other types of limits must not be more restrictive for mental health or addiction treatment than for other types of medical care

- Prescription drug costs or requirements
- Prior-approval requirements
- Clinical standards used to approve or deny care
- Availability of providers

Warning Signs: Parity Violation?

Fewer visits or days for MH/SUD care

Warning sign: The health plan covers fewer office visits or inpatient days for mental health or addiction treatment than for other types of medical care.

MH/SUD residential or partial hospital care not covered

Warning sign: The health plan does not cover residential treatment or partial hospital care for mental health or addiction treatment, but similar care is covered for other medical conditions.

Higher out of pocket costs for mental health/addiction care

Warning sign: The health plan charges more for mental health and addiction care:

- Added deductible for mental health and substance abuse care
- Higher copay for services (set fee per visit or prescription)
- Higher co-insurance (percentage of total cost)
- Medication or treatment placed on a higher tier (percentage of total cost)

Care denied unequally: Not medically necessary

Warning sign: The health plan reviews requests for mental health or addiction treatment more often or in a stricter way than for other types of care.

Health plans approve or deny requests for care based on *medical necessity*. A treatment

request may be denied because:

- It is not approved for certain health conditions
- The treatment may only work under certain conditions
- Effectiveness or safety may be in question
- The cost is higher than other types of care for the same condition

Having to ask permission more for mental health or addiction care

Warning sign: The health plan requires prior approval more often for mental health and addiction treatment than other types of care.

With prior authorization or prior approval (PA) the member or provider must contact the health plan to ask permission before starting treatment. If PA is granted, the plan will pay.

Step therapy is a type of prior authorization in which the member must try a more common, often less expensive, treatment or medication that is proven effective for most people with a given condition before they can “step” to the treatment prescribed by the provider.

Can’t find in-network mental health or addiction providers

Warning sign: It is hard to find local mental health or addiction treatment providers in the health plan network, but other types are available. Provider directory not up to date.

To keep premiums low, health plans contract with a limited number of providers who meet quality standards. In return for client referrals, providers go through a review process, agree to work for a reduced rate and follow plan procedures. This is called a provider network.

Complaints and Appeals

When care is denied, a health plan member or provider has the right to complain (about the quality of care or coverage) or to ‘appeal’ (ask for a different decision). Complaints and appeals are a standard part of the insurance business. State and federal agencies need complaints and appeals because they are helpful in finding out where the problems are and making the parity law stick.

How to prepare a complaint:

1. Health plan member and provider discuss the reason for the complaint or appeal. Write down the details.
2. Member or provider contacts the health plan customer service office to ask for a different decision.
3. If not resolved, the member or provider files a written complaint with the health plan.
4. At the same time, the member or provider contacts the state health insurance department:
    - For information
    - For help filing a complaint with the health plan
    - To file a complaint with the correct government agency.

What happens when a complaint is filed?

1. Fill out a complaint form and attached documents, if any, that provide details.
2. Submit the completed complaint form and attachments by U.S. mail, fax or email (unless a form is available online).
3. When the state insurance agency receives the form, you will receive a written notice that your complaint has been received. A file number will be assigned which you should use any time you contact them about your complaint.
4. The state insurance agency will forward the complaint to the health insurance company or agent and request a response. The company or agent has a limited time to respond, usually 30 days.
5. When the state receives a response one of the following will happen:
    a. If the complaint has been resolved, the file will be closed. You'll get a letter.
    b. If an insurance law has been violated, they will be asked to correct the problem.
    c. If the company is not abiding by the policy, they will be asked to correct the problem.
    d. If the insurer or agent has not responded to all questions or has not looked into the complaint in detail, they will be required to do so.
    e. If no violation is found, you will get a letter explaining why the case is closed.
6. It takes about 45 days from the time a complaint is received to when the problem is solved. A complex complaint could take longer.

This chart shows the government agencies responsible for different types of health plans. If you are not sure where to file a complaint or appeal, visit the HHS parity complaint website shown below. At the same time, contact your state insurance department.

Type of Health Plan	Government Agency
Employer-based plans: Large group or self-insured	Department of Labor (DOL)
Individual health plan: Federal Marketplace or State Exchange	State Health Insurance Department Centers for Medicare & Medicaid Services (CMS)
Individual or small group Non-exchange plan	State Health Insurance Department
Medicaid Managed Care or Children's Health Insurance Plan (CHIP)	State Medicaid Program (TennCare) CMS
Federal Employee Health Benefit plan (FEHB)	U.S. Office of Personnel Management
State/local government self-insured plan	U.S. Department of Health & Human Services

Not sure where to file?

Federal HHS parity complaint website
www.hhs.gov/mental-health-and-addiction-insurance-help

- Information
- Links:
  - Federal agencies
  - State insurance departments

Questions or complaints in Tennessee?

Tennessee Department of Commerce and Insurance
Phone: 615-741-2218
Email: CIS.Complaints@state.tn.us

File a complaint with the Tennessee Department of Commerce and Insurance

- For fully insured plans, individual or private plans, or non-federal government plans in Tennessee, file parity complaints here.
- File an online complaint here. At the bottom, under the dropdown box “Reason for Complaint,” click on Other. Then type “parity violation” in the box.
- You can also call the Insurance Division’s Consumer Insurance Services at (800) 342-4029 or (615) 741-2218.

File a complaint with the U.S. Department of Labor/Employee Benefits Security Administration

- This office handles parity complaints involving self- insured private employer health plans. For assistance, call (866) 444-3272 or visit: askebsa.dol.gov for information.

File a complaint with the U.S. Department of Health and Human Services

- This office handles parity complaints involving state and local government employer plans that are self-insured.
- Complaints can be filed through the HHS parity complaint portal by phone with the CMS Health Insurance Helpline at 877-267-2323 x 6-1565 or by email: phig@cms.hhs.gov or NonFed@cms.hhs.gov

Sample MH Story 1: Worksheet

A 59-year-old man with an individual health plan purchased through the state health insurance exchange:

"My brand name diabetes medication is on tier 1 with no coinsurance, but my mental health medications are on tier 3 and I can't afford $240.00 out of pocket every month.

I must 'step up' by taking less expensive psych meds for 6 weeks. I only get the one I need if the other doesn't work. I changed health plans twice before and had to 'step up' each time. Why can't they look at my record and approve the right drug from the start?"

Discussion questions:

Does this story have parity issues? If so, what are they?

What is the first step he should take?

What government agency or agencies should he contact?

Sample MH Story 2: Worksheet

A 38-year-old married woman covered by her husband's small group employer-sponsored health plan:

"My health plan requires prior authorization for mental health, but not for medical care. The doctor prescribed TMS * for my depression, but my health plan denied the service as 'not medically necessary' despite the fact that I've tried everything."

Discussion questions:

Does this story have parity issues? If so, what are they?

What is the first step she should take?

What government agency or agencies should she contact?

* TMS: Transcranial Magnetic Stimulation is used for treatment-resistant depression

Sample MH Story 3: Worksheet

A 20-year-old single woman with Medicaid managed care.
Her mother is speaking:

"Our Managed Care Organization (MCO) evaluated medical necessity for day hospital treatment almost on a daily basis. That made no sense because the decision to admit our daughter to this type of treatment was based on her receiving residential care for four weeks. Care was denied several times while she was there and it was a constant struggle to extend the stay.

I don't understand why this is different than her stay in the rehab facility after she broke her leg."

Discussion questions:

Does this story have parity issues? If so, what are they?

What is the first step she should take?

What government agency or agencies should she contact?

Sample SUD Story 1: Worksheet

A 45-year-old man with an individual health plan purchased through the state health insurance exchange:

"I'm trying to recover from a heroin habit that started after my dentist prescribed oxycodone for oral surgery.

My addiction counselor wants me to take Suboxone, but it's a tier 3 drug in my health plan. I'd have to pay $120 every month. Why am I paying such high premiums if they won't cover the care I need?"

Discussion questions:

Does this story have parity issues? If so, what are they?

What is the first step he should take?

What government agency or agencies should he contact?

Sample SUD Story 2: Worksheet

A 29-year-old married woman covered by her husband's small group employer-sponsored health plan:

"My health plan refused to pay for my residential treatment for cocaine withdrawal because they said I had exceeded my lifetime limit for residential treatment. I thought lifetime limits weren't allowed anymore."

Discussion questions:

Does this story have parity issues? If so, what are they?

What is the first step she should take?

What government agency or agencies should she contact?

Sample Consumer Complaint Form

National Association of Insurance Commissioners

Required fields are marked with an asterisk*

Please note: Entry of accented characters such as é, ă and ň, are not supported in this form.

Complainant's information:

* First name | Middle | *Last name

*****Address

*City | *State | *ZIP

County | Country | International ZIP

Email address:

Please re-enter email address as verification:

*Phone number: | Extension:

*Alternate phone number: | Extension:

How do you want to be contacted?

Insured Information (if different than above)

* First name | Middle | *Last name

Other parties involved in this problem:

* First name | Middle | *Last name

***Type of Insurance**

- Annuity
- Auto
- Commercial
- Dental
- Disability
- Group health
- Home
- Individual
- Life
- Long term care
- Medicare supplement
- Other
- Title
- Workers comp

***Reason for Complaint** check one or use ctrl key to make multiple selections

- Agent handling
- Cancellation
- Claim delay
- Claim denial
- Delays/no response
- Information requested
- Misrepresentation
- Nonrenewal
- Other
- Premium & rating
- Premium notice/billing
- Premium refund
- Unsatisfactory settlement offer

Other desc. | Other desc.

***Details of complaint**

***What do you consider to be a fair resolution?**

Maximum fair resolution length: 4,000 characters. Characters left:

Note: After the final submission of this form, you will be provided an opportunity to attach supporting documents.
Will you be mailing or attaching additional supporting information?

To download form:
https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N

Resources

Tennessee:

Dept. of Commerce & Insurance: State insurance agency staffed to answer insurance questions and assist with complaints and/or appeals.

Consumer Affairs: 615-741-2218

CIS.Complaints@state.tn.us

Download complaint form here.

TennCare: Tennessee's Medicaid managed care program

- Advocacy Program: 800-758-1638
- Complaints and Appeals: 1-800-878-3192

https://www.tn.gov/tenncare/topic/how-to-file-a-medical-appeal

Dept. of Mental Health and Substance Abuse Services: State agency responsible for mental health and addiction services.

- Help Line: 800-560-5767 Information & Referral, M-F, 8:00am – 4:30pm
- Crisis Line: 855-274-7471

Federal:

U.S. Department of Health and Human Services (HHS) Parity Portal. Website to file parity complaints and appeals with the correct government agency.

- *www.hhs.gov/mental-health-and-addiction-insurance-help*

U.S. Department of Labor (DOL)

- **EBSA (Employee Benefits Security Administration):** Federal agency responsible for employer sponsored and large self-insured health plans. 866-444-3272

  www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa

CMS (Centers for Medicare and Medicaid Services): Federal agency responsible for Medicare, Medicaid and health insurance exchange or federal Marketplace health plans.

- Helpline: 877-267-2323 extension 61565
- phig@cms.hhs.gov

SAMHSA (Substance Abuse and Mental Health Services Administration): Federal agency responsible for mental health and substance use services.

- Helpline: 800-662-4357

Advocacy Organizations:

The Kennedy Forum unites mental health advocates, business leaders, and government agencies around a common set of principles, including full implementation of the Federal Parity Law.

https://www.thekennedyforum.org/vision/parity/

Mental Health America (MHA): Addresses the needs of people with mental illness and promotes the mental health of all Americans.

https://www.mhanational.org/issues/issue-brief-parity

National Alliance on Mental Illness (NAMI): Organization of individuals and families affected by mental health conditions. Provides support, education, advocacy,

awareness.

- Helpline: 1-800-950-6264, info@nami.org
- Parity information: www.NAMI.org/parity

ParityTrack: Helps people with mental health and substance use disorders understand and exercise their rights under parity law. www.paritytrack.org

Glossary

Appeal: If a health plan will not pay a claim or drops a member from coverage, the member has the right to appeal for a different decision and have it reviewed by a third party. Insurers must explain why the claim has been denied or coverage has been dropped.

Children's Health Insurance Program (CHIP): CHIP provides health coverage for eligible children, through both Medicaid and separate CHIP programs. CHIP is funded with federal and state dollars and operated by states under federal rules.

Co-insurance: The health plan member shares the cost of a covered service. Coinsurance is a percent (for example, 20%) of the allowed cost of service. For example, if the allowed amount for an office visit is $100 and the member has met the deductible, the coinsurance payment of 20% would be $20. The health plan pays the remaining allowed amount.

Complaint: If a health plan member has reason to believe that the plan is not providing benefits as required in the health plan policy or the law, the member can file a complaint with the health plan or the state of federal government agency in charge the plan.

Consumer protections: Health care law offers rights and protections that make coverage more fair and easy to understand. Some protections may apply to plans in the Health Insurance Marketplace, other individual plans, job-based plans, and some apply to all health coverage.

Copayment, copay: A fixed amount (Example: $20) the health plan member pays for a covered service, usually at the time of service. The amount can vary by the type of covered health care service.

Credentialing: The process deciding whether a professional will be included in a health plan network. The health plan usually reviews education, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence.

Deductible: How much the member owes for covered health care services before the health insurance begins to pay. The deductible does not apply to preventive services such as annual check-ups or mental health screening, meaning that the plan will pay even before the deductible has been met.

Essential Health Benefits (EHB): Under the Patient Protection and Affordable Care Act, all individual and small group health plans (except grandfathered plans) must cover 10 types of care: (1) outpatient services; (2) emergency services; (3) hospital care; (4) maternity and newborn care; (5) behavioral health services; (6) prescription drugs; (7) rehabilitation; (8) lab services; (9) preventive and wellness services; and (10) children's services, including dental and vision. All EHB must comply with federal parity law.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a preferred drug list (PDL).

Grandfathered health plan: Health plans that existed on March 23, 2010, and haven't cut benefits or increased member costs. Grandfathered do not have to offer parity or other protections required under the Affordable Care Act. Insurance companies must notify members who have grandfathered plans.

Individual health plan: Health coverage purchased by an individual for self or family either through a health insurance exchange, or directly from the health insurance company.

Medical necessity, medically necessary: Health care services or supplies needed to prevent, diagnose, or treat a condition, and that meet accepted standards of medicine

Narrow network: To lower costs, health plans contract with a limited number of service providers, hospitals, labs and pharmacies. The monthly premium may be lower, but members pay more if they use out-of-network care.

Out of pocket cost (OOP): The amount owed by a health plan member during a policy period before the health insurance plan begins to pay 100% of the allowed amount. This limit does not include the premium, balance-billed charges or costs for benefits not covered under the plan.

Parity (Mental Health and Addiction): Most health insurance plans are legally required to cover mental health and addiction treatment at the same level as other types of medical care.

Provider Network: Facilities, providers and suppliers contracted with a health plan to provide care to members. The health plan covers more of the cost of care for in-network providers. However, for a given type of care, if no in-network provider is available within a certain distance from the member's home, the health plan is required to pay for an out of network provider.

Prior authorization, prior approval (PA): A decision by the health plan that a health care service, treatment plan or prescription drug is medically necessary. Sometimes called preauthorization, prior approval or precertification.

Medically necessary, medical necessity: Health care services or supplies needed to prevent, diagnose or treat an illness or condition and that meet accepted standards of medicine**.**

Non-quantitative treatment limits (NQTL): Standards used to review treatment requests for type and duration of care that do not involve numbers of visits or days. NQTLS include prior approval, step therapy and other techniques to decide whether a service is medically necessary. Under the ACA, an NQTL must not limit mental health or addiction treatment more than medical or surgical care.

Quantitative treatment limits (QTL): Standards that limit the type or duration of benefits that involve a number of visits, days or costs. Examples include the number of visits or inpatient days, copays, coinsurance or annual dollar limits. Under the Patient Protection and Affordable Care Act (ACA), QTL must be no more restrictive for mental health or substance use care than for medical surgical care.

Self-insured/self-funded health plan: A health plan in which the employer assumes the financial risk for providing health care benefits to its employees.

Small group health plan: Employer-sponsored health insurance offered by an employer with 2 to 50 employees.

Step therapy, fail first: A type of prior approval in which the member must try and fail to respond to certain treatments that are less expensive, but effective for most people with a given condition, before they can "step" to a different treatment. For example, the plan may require a generic drug, then a less expensive brand-name drug from its formulary, before covering a similar, more expensive brand-name prescription drug.

Substantially all: If a type of cost requirement or treatment limit applies to substantially all medical/surgical benefits in a class, then that requirement or limit may apply to mental health or substance use disorder benefits if it is on par with two-thirds or more of the medical/surgical benefits for the same class of treatment.

Tier: A level of health coverage for a given type of care. For example, health plan members would pay more out of pocket costs for a prescription drug on tier 3 than for a medication on tier 1.

Utilization management (UM): Array of procedures used by insurers to evaluate whether requested care is medically necessary, efficient and in line with accepted medical practice. Examples of utilization management practices include prior authorization and step therapy.