

Navigating Parity Toolkit

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

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About the Maryland Parity Project

Since 2010, MHAMD's Maryland Parity Project has educated insured Marylanders of their rights in accessing mental health and substance use disorder treatment under The Mental Health Parity and Addiction Equity Act of 2008. We work to reduce barriers to accessing behavioral health care by:

- educating consumers and providers of their rights
- offering resources and case assistance to those whose rights may have been violated
- advancing public policy to ensure the goals of the Maryland and Federal Parity Laws are realized

Parity Law

What Is the Parity Law?

State and federal parity laws aim to create fairness in insurance coverage for mental health and addiction treatment by requiring coverage and management of MH/SUD treatment to be equal to physical health coverage. The federal and state laws provide different levels of protection and different rights. For plans that are covered by both laws, any stronger protections in Maryland Law supersede the Federal Law.

What Is the Federal Mental Health Parity Law?

The 2008 Wellstone and Domenici Mental Health Parity and Addiction Equity Act (The Parity Law) aims to create equality between insurance coverage for medical/surgical treatment and mental health/substance abuse treatment. The Parity Law requires health insurers to ensure that financial requirements (deductibles, co-pays, etc.) and treatment limitations (visit limitations, review procedures) for mental health and substance abuse treatment are no more restrictive than requirements or limitations that are applied to medical/surgical benefits.

How Does the Parity Law Protect Me?

The Federal Parity Law does **NOT** require that insurers offer mental health or addiction treatment coverage. The Parity Law also does not address diagnoses. Plans are allowed to decide which diagnoses will be covered in accordance with applicable state law. Some states require that certain diagnosis be covered. Maryland does not require that any specific mental health diagnoses be covered by insurance plans. The Parity Law requires that if an insurer offers **ANY** mental health or addiction benefits, the coverage must be equal to medical/surgical benefits.

To enforce this, health plans must place all benefits into six areas for comparison purposes:

1. In-network, inpatient
2. In-network, outpatient
3. Out-of-network, inpatient
4. Out-of-network, outpatient
5. Emergency services
6. Prescription drugs

If a 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.

Limits on Days, Visits or Copayments

The Parity Law does not prohibit insurers from limiting or managing the mental health benefit, but in order to make sure benefits are equal to mental health and addiction medical/surgical benefits, there are specific regulations that address how plans can limit your access to treatment.

These limits include but aren't limited to:

1. Limit on the number of visits you can make in one year
2. Limit on the number of days you can stay in the hospital
3. Amount of your copayment each time you visit your provider
4. Amount of money you pay for each service (testing, prescriptions, etc.)
5. The law does **NOT ALLOW** limits for your mental health or addiction treatment benefits that are separate from your medical or surgical treatment. It also does **NOT ALLOW** any limits on mental health/addiction treatment that are more restrictive than for medical/surgical treatment.

The exact regulatory language that defines the standard for determining any violations in this area is, "Any quantifiable treatment limitation must be no more restrictive than the predominant requirement or limitation that is applied to substantially all medical/surgical benefits."

Example: A plan cannot have a limit of five days of inpatient treatment for mental health or addiction treatment if they do not have a limit on the number of inpatient days for medical or surgical care. Many plans have removed blanket visit or day limits in order to comply with the Parity Law.

Other Limits on Treatment

Plans often have other ways they may limit access to care that aren't as simple as limits on visits or co-payments. Examples include: how a plan determines if your treatment was medically necessary; if this review is done before, during or after treatment; the amount of money the plan pays its network providers for specific services; and the number of providers on its in-network panels.

The Federal Parity Law addresses these complicated limits by requiring that they be comparable to the medical/surgical limits and no more strictly applied to mental health/addiction benefits.

The exact regulatory language is, "Any nonquantifiable treatment limitation must be comparable and no more stringently applied for mental health/addiction than for medical/surgical benefits."

Because there are many different types of "nonquantitative treatment limitations," and they are varied in the way they are applied, it can be difficult to determine whether your insurance plan is violating the Parity Law. However, there are some limitations that the Department of Labor has identified as potential red flags. See examples in the What Does a Parity Violation Look Like? section of this document.

Appeal and Disclosure Rights

The Federal Parity Law also grants consumers and providers rights not related to limits on treatment. These rights require that insurers provide consumers with certain information when treatment is denied or coverage changes are made.

- Insurers must disclose the criteria used for medically necessary determinations to consumers and providers upon request and provide an explanation for how it is applied. This is important because many treatment denials are based on this determination.
- Insurers must provide the reason for any denial of treatment in writing and free of charge. The insurer must send this upon denial but also upon request by a provider or consumer.
- If a plan decides to no longer offer mental health or addiction benefits, it must notify members immediately.

Additional Protections for Plans Covered by the Maryland Parity Law

Individual, small group and large group, fully insured plans make up only 30% of plans sold in Maryland. These plans are regulated by Maryland law and the Maryland Insurance Administration and **MUST** include the following benefits:

- Inpatient
- At least 60 days of partial hospitalization
- Outpatient, including office visits and psychological and neurological testing
- May be managed for medical necessity, but that process must comply with the Federal Parity Act
- May not charge a co-payment for methadone treatment for opioid misuse that is more than 50% of the daily cost of this treatment
- Must provide a notice to all members that the plan is covered by the Federal Parity Law and that any member may contact the Maryland Insurance Administration for more details.

Is My Insurance Plan Covered?

In order to fully understand your rights, it is important to know what type of insurance plan you have. Not all plans are covered by Parity Laws, and some plans are covered by only the federal law. If you are unsure what type of plan you have, ask your employer's HR Director or call the number on the back of your insurance card.

Type of Plan	Example	Federal Parity Law	Maryland Parity Law	Where to File a Complaint	Notes
Self Insured Employer (large or small)	Johns Hopkins Employee Health Plan	Yes	No	US Dept. of Labor	
Insured Employer (large or small)	Small nonprofit such as MHAMD	Yes	Yes	Maryland Insurance Administration and/or US Dept. of Labor	These plans MUST provide MH/SUD benefits.
Individual Plan	You purchase this plan for yourself, including via Maryland Health Connection	Yes	Yes	Maryland Insurance Administration and/or US Dept. of Labor	These plans MUST provide MH/SUD benefits.
Federal Government Employee Plan	Any federal employee insurance, except military or veterans	Yes	No	US Office of Personnel Management	
State or Local Government Employee Plan	MD State employee health plan	Yes	No	US Dept. Health & Human Services	State and local government plans are covered under Federal Parity Law only, but may request an exemption.
Veterans/Department of Defense Plan	Any active military or veteran plan	No	No	Tricare	While DOD and Tricare plans are exempt from both laws, recently Tricare has decided to comply with most of the parity regulations.
Medicare	Health plans for individuals 65 and older	No	No	US Centers for Medicare & Medicaid Services	Medicare is specifically exempted from the Federal Parity Law, and state laws cannot regulate Medicare. The 2008 Medicare Improvement for Patients and Providers ACT (MIPPA) created some equality in outpatient behavioral health treatment for Medicare patients. As of 2014, Medicare will pay 80% of the cost of outpatient behavioral health services. Currently, Medicare has a 190-day lifetime limit for inpatient mental health care. This same limit does not exist for inpatient medical or surgical care.
Medicaid	Health plans for individuals with low income (below 139% of federal poverty level) or who meet other criteria	Yes	No	US Centers for Medicare & Medicaid Services	Individuals who receive any Medicaid benefits via a managed care organization (HealthChoice in MD) are entitled to parity protections.

What Does Self Insured Mean?

Normally an employer buys insurance and pays a monthly premium for your coverage, although you may pay a portion through payroll deduction. The insurance company pays medical bills for insured employees. If employees have medical bills that exceed the total premiums collected by the insurance company, the insurer is "at risk" and pays 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. These plans are not regulated by state laws.

What Does a Parity Violation Look Like?

The Mental Health Parity and Addiction Equity Act (Federal Parity Law) doesn't require that mental health and substance use disorders be a covered benefit. But the combination of other Maryland and federal laws in effect mean that mental health and substance use disorder treatment must be covered. There are few, if any, insurance plans provided to Maryland residents that can legally say that they don't cover any mental health or substance use disorder treatments. Nothing below is automatically a parity violation, but any of the examples or scenarios may indicate a potential violation of the Parity Act and should be explored further. This often means asking the insurance company for more information.

Quantitative Limitations {Violations in this area are very rare in Maryland.}

- The complete exclusion of any level of treatment, such as residential, for either a mental health or substance use disorder.
- Higher co-payments or separate deductibles for behavioral health services. In Maryland, most outpatient co-payments for behavioral health should be the same as for primary care.
- Blanket limit on the number of outpatient visits or days for an inpatient stay. Unless a plan also has a limit on the number of visits you can make to a primary care doctor or the number of hospital inpatient days regardless of condition or illness, it cannot have them for behavioral health. The plan can use an authorization requirement to determine how many visits or inpatient days are medically necessary for a given condition or situation.

Non-Quantitative Limitations {These scenarios are more common in Maryland.}

- Frequent or time-consuming authorization process for outpatient or inpatient care. If the process to obtain authorization for treatment seems burdensome, it might be a parity violation.

• **Example:** Dr. Smith provides outpatient mental health services and has become increasingly frustrated by ABC insurance company's requirement that he obtain authorization after every 20 sessions with a client no matter the severity of their mental illness. Not only must he submit an electronic authorization, but he is often required to submit a new treatment plan and then justify the continuation of treatment on a 30-60 minute phone call with an insurance company.

• **Example:** Natalie was admitted to XYZ hospital's inpatient psychiatric unit after presenting at the Emergency Room with severe depression and thoughts of harming herself. The admitting physician submitted an authorization for the recommended stay of 7 days. Natalie's insurance company did not deny the stay, but only authorized 3 days. After the 3 days, the attending psychiatrist or hospital social worker must submit another authorization, requiring the psychiatrist to justify the stay on a 60-minute phone call with the insurance company. The insurer authorized 2 additional days. Although the total authorized time of 5 days doesn't reach the originally recommended 7 days of inpatient treatment, a denial of treatment is not sent. Natalie can still appeal this decision to not authorize a longer inpatient stay.

- Requirement that a client has failed at a lower level of treatment prior to authorizing a more intensive level of care.

• **Example:** ABC Insurance Company has medical necessity criteria for residential treatment states that the patient must have a documented history of failure at a lower level of care, such as outpatient or intensive outpatient treatment. Effectively, this means that ABC will not authorize residential treatment unless the patient has previously failed at outpatient or intensive outpatient treatment.

Non-Quantitative Limitations (Continued)

- Requirement to obtain authorization for inpatient or residential treatment – the client must be likely to demonstrate improvement. This is often more likely to be seen for residential substance use disorder treatment than for mental health treatment.

• **Example:** Bob sought residential rehab treatment for his heroin addiction. During his assessment, the treatment facility found that Bob may also have an addiction to alcohol. Bob does not believe he needs treatment for alcoholism, but is very ready to enter a 28-day program for his heroin addiction. Bob's assessment notes were included in the authorization request to his insurer. They have denied authorization for treatment as they have determined Bob is not likely to show improvement because he is reticent to accept treatment for his alcohol use.

- Blanket prior authorization requirement for all prescription drugs used in substance use disorder treatment. A new Maryland law taking effect in 2018 prohibits insurers from instituting a prior authorization for opioid treatment medications. Therefore, 2018 plans that require this would be violating Maryland law, and a complaint should be filed with the Maryland Insurance Administration.
- Requirement that provider implement treatment contract with consequences for any opioid medication assisted treatment.

• **Example:** ABC managed care organization requires that prior to any patient receiving a prescription for buprenorphine to treat their heroin addiction they must have an active treatment contract with the prescriber. The agreement must outline the provisions of the contract {no use of other substances, attendance and weekly counseling sessions, etc.} and must have consequences for violations of the contract, such as mandatory group or additional session if the patient has a positive urine screen for another substance {marijuana or benzodiazepines}.

- Other requirements that might violate parity, but are more likely noticed by providers include include the way that insurers determine the rates they pay providers for the different services; the criteria that insurers use to determine when they are closing panels and not accepting more providers in the network; and onerous and limiting credentialing and paneling requirements for providers to join networks.

How Do I File a Complaint?

What Do I Do If I Think My Plan Has Violated the Parity Law?

Consumers and providers have increased protections because of the Federal Parity Law, but it is up to all of us to take advantage of these rights and hold insurers accountable. If you, a loved one or client are not receiving care that is needed, take action and file an appeal with your insurer or a complaint with the proper government agency. You can do this on your own following the steps below.

Step 1: Figure Out the Type of Plan You Have and Which Government Entity Can Help. 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 plan is self or fully insured. 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 or call the number on your insurance card.

Step 2: Obtain Written Reason for Denial. If you have been denied coverage or reimbursement for treatment, your insurer must provide you and/or your provider with a reason for this denial in writing. If you have not received this document, you have the right to request it from your insurer, free of charge and in a timely manner. You can call your insurer with your member number and the date of treatment request to get this document.

Step 3: Ask for Help. Your provider can help with appeals to your insurer. They are often the first to receive billing information, including denials from insurers, and may have information needed in order to continue the process. Sometimes your provider may have already filed an appeal on your behalf. If you decide to file the appeal alone, you should notify your provider because the insurer may need to speak with him or her. The Maryland Attorney General Health Education and Advocacy Unit will also help with appeals of treatment denials.

Step 4: Gather Materials. The items listed may be useful if you continue through the appeal process. Collecting documents and taking notes can be tedious but are often very important to winning an appeal. **1. Explanation of Benefits Booklet:** This is the book you should have received when you first got your health insurance information. It 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. **2. Reason for Denial of Treatment or Reimbursement:** This must be presented to you in a timely manner and free of charge. **3. Definition of Medically Necessary:** The insurance company must provide you with written criteria it uses to determine whether your treatment was medically necessary and an explanation of how it applied this criteria. **4. Letter Explaining Necessity of Prescribed Treatment:** Your provider will give you a letter describing why your treatment was necessary. **5. Medical Bills and Tracking of Visits:** Keep copies of bills and records of visits for treatment. When in doubt, keep any documents you receive about your treatment until the appeal and complaint process is complete. **6. Good Notes:** Document all calls and conversations you have regarding your appeal. Keep track of names and dates of all conversations.

Step 5: 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 representative at your employer or call the number on the back of your insurance card.

Step 6: File A Complaint. You can file a complaint of a potential parity violation at any time, but after you have exhausted internal appeals with your insurer, you can ask for an external review of the denial. This is done by filing a complaint with the proper government agency. In the complaint letter be sure to reference the Federal Parity Law and any potential violations. We have prepared some sample letters that you may use to file a parity complaint.* Most complaints are filed with the Maryland Insurance Administration (MIA). Exceptions are the following:

1. Complaints for large employer, self insured plans and state and local government plans are filed with the US Department of Labor.
2. Complaints for federal government plans are filed with US Health and Human Services.

* Sample letters are available in the following Appendix

Where Can I Go For Help or to Learn More?

Maryland Resources

Maryland Attorney General Health Education and Advocacy Unit

For information or 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 the Maryland Insurance Administration

<http://insurance.maryland.gov/Consumer/pages/FileAComplaint.aspx>

National Resources

Parity Track

An initiative of the Kennedy Forum provides state-based resources on parity legislation, regulations and where to go to get help filing a parity complaint or appeal in your state. Its interactive map is a great resource to compare and review your state's parity work. Parity Track also has a registry of complaints to track the implementation of the law and is asking that individuals log their complaints and share their stories, so they may be used in continued advocacy.

<https://paritytrack.org/>

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.

www.parityispersonal.org

US Department of Labor

For information on how to file a federal claim

<https://www.dol.gov/agencies/ebsa>

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 and Medicaid Services

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

<https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/>

Federal Register

To see the full text of the Final Regulations

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

Downloadable Resources

[Simplifying the Appeals Process](#)

The Kennedy Forum and Parity Implementation Coalition published this resource guide to increase the general public's understanding of the law, how to file a complaint and the steps to appeal denied claims.

[Parity Act Brochure – Equitable Insurance Coverage for Mental Health and Drug Treatment](#)

This brochure outlines a number of questions consumers with a mental health or substance use disorder may have when accessing health care. Following each question, the brochure offers brief answers along with helpful resources.

[Parity Act Resource Guide](#)

Student-attorneys of the University of Maryland Carey School of Law Drug Policy and Public Health Strategies Clinic developed this resource guide for providers and consumers to identify parity issues with insurance companies and entities that administer Medicaid.

[Accessing Mental Health Care Fact Sheet](#)

Download this fact sheet for consumers who need assistance gaining access to care or filing an appeal/complaint with an insurer.

What Is the Affordable Care Act (ACA)?

The Affordable Care Act, enacted in 2010, has three main goals: **1)** make affordable health insurance available to more people; **2)** expand the Medicaid program to cover all adults with income below 139% of the federal poverty level; and **3)** support innovative medical care delivery methods designed to lower the costs of health care generally.

- Maryland expanded Medicaid eligibility to adults with income below 139% of federal poverty level. This population receives the same Medicaid benefit package and must choose a managed care organization.
- Individuals and families between [139-400% of the federal poverty level](#) qualify for advanced tax credits that will help pay for premiums for insurance plans purchased through the health exchanges.
- [Maryland Health Connection](#) is where people can find health plans during open enrollment, and assistance is available to help with enrollment in these plans.
- Dependent children under the age of 26 will be allowed to stay on their parents' health plans.
- Insurance companies must spend 80% of every premium dollar on health care claims, meaning they must spend only 20% on administration or profit.

If you are having trouble understanding the effectiveness of the ACA, check out this [video](#) from the Henry J. Kaiser Family Foundation.

How Does the Affordable Care Act Protect Me?

In addition to the provisions already listed, the Affordable Care Act requires insurance companies to comply with all of the requirements below that further ensure that individuals are able to access timely and affordable coverage.

- **Insurance companies may no longer deny coverage or charge people more for pre-existing conditions.** This means individuals with a mental illness or substance use disorder cannot be denied coverage or charged more than other individuals.
- **Insurance companies can no longer implement annual or lifetime limits on coverage or benefits.** This means that you cannot exhaust your insurance benefits over a year or a lifetime.
- As a part of the Essential Health Benefits, **all individual and small group plans must include mental health and substance use disorder benefits at parity as of 2014.** Maryland's Essential Health Benefit Plan that must be included in all Qualified Health Plans includes the robust package of mental health and substance use disorder benefits. These benefits include a full complement of services: inpatient, outpatient, partial hospitalization, intensive outpatient and residential treatment for mental health and substance use disorders.
- **All Qualified Health Plans must meet certification standards,** which include a requirement that the insurer have an adequate network of providers, including a sufficient number of mental health and substance use disorder providers so that individuals may access treatment without unreasonable delay.

Where Can I Get Help or Find More Info?

Healthcare.gov

The Department of Health and Human Services has established a page to answer your questions about the Affordable Care Act.

[Substance Abuse and Mental Health Services Administration](#)

Information on how the Affordable Care Act affects behavioral health consumers and providers

[The Centers for Medicare and Medicaid Services](#)

For more information about Medicaid expansion and Medicare changes

[The Center for Consumer Information and Insurance Oversight](#)

CCIIO is the agency tasked with implementing the Affordable Care Act. You will find more information on the private insurance market reforms on this site.

[Maryland Health Connection](#)

This site is the face of the health insurance marketplace. You can compare and purchase individual health plans during open enrollment and see if you qualify for a special enrollment.

[Consumer Health First](#)

This organization is very active in health care reform implementation in Maryland. The website has a wealth of information about Maryland's efforts and how you can get involved.

[HealthCare Access Maryland](#)

HealthCare Access Maryland helps residents enroll in public health care coverage and navigate the complex health care system and was recently selected as Maryland's Central Region Connector Entity. You can get more information about Medicaid and Exchange Enrollments at this site.

[Kaiser Family Foundation](#)

Kaiser is a non-profit, private operating foundation focusing on the major health care issues facing the U.S. It provides a multitude of studies and policy briefs related to health care reform, including a [tool that will help calculate tax subsidies](#) and insurance premiums for those buying through the health benefit exchange.

Downloadable Resources

[Affordable Care Act Implementation Fact Sheets and FAQs](#)

The Centers for Medicare and Medicaid Services has numerous fact sheets and FAQs on the implementation of the ACA for stakeholders and consumers.

[Medicare and Your Mental Health Benefits](#)

This Centers for Medicare and Medicaid Services publication may provide more information about covered benefits and cost-sharing.

[FAQs about Affordable Care Act Implementation and Mental Health Parity Implementation](#)

Developed by the Departments of Labor, Health and Human Services, and Treasury, this list contains important questions from stakeholders to help people understand the laws and their benefits.

Where Can I Get Help or Find More Info?

Downloadable Resources (Continued)

[Health Care Reform: Critical Issues for Newly Insured Behavioral Health Consumers](#)

This contains useful information on patient parity rights, components of the Affordable Care Act and broader reform efforts.

[Health Care Reform FAQs Guide](#)

The University of Maryland Carey School of Law Drug Policy and Public Health Strategies Clinic has released a collection of "Frequently Asked Questions" with answers for providers and patients who are seeking affordable health care coverage.

[How Insurance Works](#)

This booklet explains insurance, why it is importance, different insurance programs and the benefits of health insurance.

[Medicaid Enrollment Flyer](#)

Download this flyer on how to enroll through a Certified Navigator and for useful tips for plan selection.

[Mental Health America Qualified Health Plan Selection Kit](#)

Created by Mental Health America, this guide details questions to consider when choosing a qualified health plan and outlines possible mental health services one may want to access.

[Redeterminations Fact Sheet for SUD Providers](#)

Download this fact sheet for providers who serve Medicaid beneficiaries.

[Selecting an Insurance Plan that Meets Your Behavioral Health Needs](#)

This fact sheet details tips for selecting a plan and a worksheet to compute plan costs.

Maryland Insurance Protections

What Can I Do If I Can't Find a Provider in My Insurance Network?

Maryland law entitles consumers to, "access to primary and specialty care without unreasonable delay or travel." This means your insurance company must maintain an adequate network of providers to ensure that you do not have to wait extended time for an appointment or travel long distances.

If you are having difficulty getting an appointment with an in-network mental health provider, there are steps you can take before you resign yourself to going out of network for care. Ask your insurance company to give you the contact information for a few providers who are accepting new patients and available for appointments in the next few weeks. If they are unable to do this, you can request that they provide a special case agreement, allowing you to visit an out of network provider, but at in-network cost, which could save you hundreds of dollars. If you are still unable to find an in-network provider, you can lodge a complaint with the [Maryland Insurance Administration](#).

Are there Protections if I Change My Insurance Plan?

As of 2015, all insurers in Maryland are required to provide continuity of care provisions for individuals who are transitioning from one plan or MCO to another. These 90-day provisions will enable individuals to carry a prior authorization for a current course of treatment with them to the new plan, as well as, allow an individual to continue to see their current provider at in-network cost-sharing even if that provider does not participate with the new insurance plan. If your insurer doesn't honor this, you should contact the [Maryland Insurance Administration](#).

Important Insurance Terminology

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

Behavioral Health

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

Classifications of benefits

For the purposes of the federal parity regulations, plans are divided into 6 different categories of benefits:

1. In-network, inpatient
2. In-network, outpatient
3. Out-of-network, inpatient
4. Out-of-network, outpatient
5. Emergency services
6. Prescription drugs

Coinsurance

Refers to money that an individual is required to pay for services, after a deductible has been paid. Coinsurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Deductible

A specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Under the parity regulations, plans may not implement a separate deductible for mental health or addiction treatment.

ERISA (Employee Retirement Income Security Act of 1974)

Establishes minimum standards for pension plans in private industry and provides for extensive rules on the federal income tax effects of transactions associated with employee benefit plans. Section 514 preempts all state laws that relate to any employee benefit plan, with certain, enumerated exceptions, including state insurance, but a limitation is placed on the insurance exception, which essentially provides that state insurance law cannot regulate employer self-funded benefit plans. These self-funded plans are often referred to as ERISA plans.

Fully-Insured

In a traditional fully-insured health plan, your company pays a premium. The premium rates are fixed for a year, and you pay a monthly premium based on the number of employees enrolled in the plan. The insurance company pays all of the medical claims for the employees and therefore holds the risk.

Generic Drug

A prescription drug that is 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 and are usually the preferred drug of a health plan.

Important Insurance Terminology

In-network

This refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts. In-network is part of two classifications of benefits under the law, in-network, inpatient and in-network, outpatient.

Inpatient

A term used to describe a person admitted to a hospital for at least 24 hours.

Large Group

Generally, those are business with more than 50 employees. The laws about how coverage can be issued to large groups are different than those for small groups, and the way that premium rates are determined is also different. These health benefit plans are regulated under the Parity Law and must meet the standard.

Medically Necessary

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

No More Restrictive

Parity regulations clarify this as, "If a restriction is applied to substantially all the benefits and it is the predominate standard it can be applied no more restrictively to the mental health or addiction benefits than the medical/surgical benefits." For example, a plan may not make a determination that no mental health inpatient treatment is covered due to lack of medical necessity, but provide panel review to determine the medical necessity of inpatient treatment for medical/surgical benefits.

Non-Quantitative Treatment Limitation

A limitation that cannot be expressed numerically. These are cost containment strategies, often referred to as care management. It includes requirements such as prior authorization, step-therapy, prescription drug formulary creation, utilization review, etc.

Out-of-network

Usually refers to health care providers who are considered nonparticipants in an insurance plan. Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company. Out of network applies to two of the classifications of benefits: out-of-network, inpatient and out-of-network, outpatient.

Parity

The quality or state of being equal. Mental health parity is the recognition of mental health conditions and addictions as equivalents to physical illnesses.

Important Insurance Terminology

Predominant

The parity regulations define “predominant” as a requirement or limit applied to 50% of medical/surgical spending in a category. Requirements or limitations for one medical/surgical benefit in a category do not qualify as predominant. For example, 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.

Prescription Drug Formulary

A list of prescription medications selected for coverage under a health insurance plan. Drugs may be included on a drug formulary based upon their efficacy, safety and cost-effectiveness. Some health insurance plans may require that patients obtain preauthorization 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 (Pre-certification, Prior Authorization)

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 some treatments or for certain drugs. 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.

Quantitative Treatment Limitation

A limitation on treatment that can be expressed in numbers. Examples include: visit limitations, inpatient day limitations and co-insurance requirements such as co-payments.

Self-Insured

A self-insured plan is when the employer holds the risk of paying for the employee’s health benefit claims. Normally an employer buys insurance and pays a monthly premium for your coverage, although 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 pays the difference. Some large companies prefer to hold the risk themselves (self-insured) and contract with insurance companies to only administer their insurance plan (i.e. handling enrollment and paying health care 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 Parity Law and are exempt from the standard.

Somatic Care

Affecting the body rather than the mind, often referred to as medical/surgical care

Important Insurance Terminology

Standard of Care

A clinically recognized diagnostic and treatment process that a provider should follow for a certain type of 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 categories of benefits. If 2/3 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%.

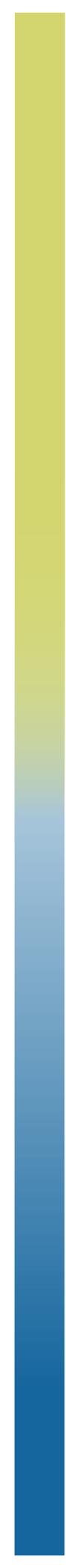
Usual, Customary and Reasonable (UCR) Charge

The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. It is often employed in determining Medicare payment amounts.

Utilization Review

This term is often used to describe a treatment limitation that plans use to determine if a patient's use of health care services was medically necessary, appropriate and within the guidelines of standard medical practice.

Utilization Management/Review may also be referred to as Medical Review. It can be done prior to treatment, during treatment (concurrent) or post-treatment (retrospective). Retrospective is considered the least restrictive, and prior is considered the most restrictive.



Appendix

[SAMPLE Parity Complaint Letter ALLOWABLE AMOUNT]

[date]

[address]

[member number if applicable]

Ms. Mary Kwei, Chief, Complaints, Appeals and Grievances Division
Maryland Insurance Administration
2700 St. Paul St., Suite 2700
Baltimore, MD 21202

Ms. Kwei,

I am writing regarding [insert insurer/plan name] reimbursement process for out of network behavioral health services (BHS). Because I was unable to find an in-network clinician to provide [insert service], I was forced to seek behavioral health care out of network, which resulted in [insert total amount of out of pocket expenses]. This letter serves to raise concerns of whether the process [insert insurer] used to establish the allowable amount for [insert service] is in compliance with the Final Regulations established pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

[Insert paragraph describing the issue]

The determination of provider reimbursement rates and allowable amounts that can be charged for a service is a nonquantitative treatment limitation (NQTL) as defined in the final regulations. If the process for establishing the allowable amounts for services are not applied to similar levels of medical/surgical care in the same manner, then the above-described process for BHS is a more stringent and non comparable application of an (NQTL) as defined by the Parity regulations (45 CFR 146.136c(4)) and is therefore noncompliant with MHPAEA. The rule governing NQTLs is as follows:

(4) Nonquantitative treatment limitations – (i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

We are unable to determine how [insert insurer] establishes the allowable amount for similar levels of medical/surgical care, and what, if any processes, strategies, factors, or evidentiary standards were used to develop and apply this requirement as we do not have access to the allowable amounts nor the process for establishment of them for medical/surgical care. The use and application of this process may be in violation of the regulation's "comparable and no more stringently" standard.

The regulations state clearly that any "processes, strategies, evidentiary standards, or other factors" used in applying a NQTL to BHS benefits in a classification must be "comparable to" and be applied "no more stringently" than the processes, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits. Given the aforementioned concerns, we have a number of questions and requests regarding whether this policy comports with the parity requirements. We request that MIA require [insert carrier] to provide documentation and required analysis to respond to the following questions:

- 1. What are the processes, strategies and evidentiary factors used to establish the allowable amount for behavioral health services?**
- 2. What are the processes, strategies and evidentiary factors used to establish the allowable amount for comparable medical/surgical services?**
- 3. What analysis has been done to determine that the processes, strategies, and evidentiary factors used are comparable and no more stringent than those used to establish the allowable amounts for similar medical/surgical services?**

ERISA regulations 29 CFR 2520.104b-1 outlines the legal obligation regarding the disclosure of plan documents. The Department of Labor issued guidance in December 2010 stating plan documents include the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits.

Finally, the Department of Labor has recently released a list of “red flags” or warning signs of nonquantitative treatment limitations that warrant further investigation to determine whether their application to a particular benefit is in compliance with the federal parity law. You will note that reimbursement rates are on the list, which can be obtained at this link.

<https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

Thank you for your time in investigating this matter.

[SAMPLE Parity Complaint Letter FAIL FIRST]

[date]

[address]

[member number if applicable]

Ms. Mary Kwei, Chief, Complaints, Appeals and Grievances Division
Maryland Insurance Administration
2700 St. Paul St., Suite 2700
Baltimore, MD 21202

Ms. Kwei,

I am writing regarding [insert insurer/plan name] fail first requirement for certain behavioral health services (BHS). This letter serves to raise concerns of whether the fail first requirement embedded in the medical necessity criteria for [insert service] is in compliance with the Final Regulations established pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

[Insert paragraph describing the issue]

While MHPAEA does not prohibit the use of utilization review nor the use of fail first requirements it does require that they be comparable to and no more stringent than what is applied to medical/surgical care. We are unaware of comparable requirements for this level of services for medical/surgical conditions.

The utilization review requirement is a nonquantitative treatment limitation (NQTL) as defined in the final regulations. If the fail first or step-therapy requirements for [insert services] are not applied to similar levels of medical/surgical care in the same manner, then the above-described medical management protocol for BHS is a more stringent and non comparable application of an (NQTL) as defined by the Parity regulations (45 CFR 146.136c(4)) and is therefore noncompliant with MHPAEA. The rule governing NQTLs is as follows:

(4) Nonquantitative treatment limitations – (i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

[Insert insurer] has a fail first requirement for [insert services]. We are unable to determine whether insurer employs a similar fail first requirement for similar levels of medical/surgical care; if so, how this requirement is applied; and what if any processes, strategies, factors, or evidentiary standards were used to develop and apply this fail first requirement as we do not have access to the medical necessity criteria for medical/surgical care. The use and application of this fail first requirement may be in violation of the regulation's "comparable and no more stringently" standard and the "no separate treatment" limitation.

The regulations state clearly that any "processes, strategies, evidentiary standards, or other factors" used in applying a NQTL to BHS benefits in a classification must be "comparable to" and be applied "no more stringently" than the processes, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits. Given the aforementioned concerns, we have a number of questions and requests regarding whether this policy comports with the parity requirements. We request that MIA require [insert carrier] to provide documentation and required analysis to respond to the following questions:

- 1. Which covered health plan services for medical/surgical conditions have similar fail first requirements?**
- 2. What are the processes, strategies and evidentiary factors used to determine when and how to apply fail first requirements to behavioral health services?**
- 3. What are the processes, strategies and evidentiary factors used to determine when and how to apply fail first requirements for similar medical/surgical services?**

The Parity Statute clearly outlines the legal obligation regarding the medical necessity criteria disclosure requirements:

42 CFR 146.136(d)(1) Availability of plan information - (1) Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

Also ERISA regulations 29 CFR 2520.104b-1 outlines the legal obligation regarding the disclosure of plan documents. The Department of Labor issued guidance in December 2010 stating plan documents includes the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits.

Finally, the Department of Labor has recently released a list of “red flags” or warning signs of nonquantitative treatment limitations that warrant further investigation to determine whether their application to a particular benefit is in compliance with the federal parity law. You will note that fail first requirements are on the list, which can be obtained at this link.

<https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

Thank you for your time in investigating this matter.

Sample Letter for Attaching to MIA Complaint Form

Date: **[insert date]**

To: Maryland Insurance Administration

From: **[insert name]**

Re: Inability to get an appointment with in-network provider

I am unable to secure an appointment with an in-network mental health provider **[insert patient name and relationship to insurance policy holder]**. My insurer **[insert name]** provided a list of in-network providers which includes many providers that are not taking new patients or that are unable to give me an appointment **[insert wait time]**. I have called **[insert number]** providers and have spent **[insert number of hours]** on the phone trying to get an appointment. **[add other details about the wait or travel distance for an appointment and any discussion with the insurer]**.

I believe I am entitled to an appointment with an in-network provider without unreasonable delay or travel according to MD Code, Insurance Article 15-112(j). Also MD Code, Insurance Article, 15-830(d) requires that insurers update their panels indicating which providers are no longer accepting new patients. I do not believe that **[insert insurer]** has done this within the required timeframe. Not only is the insurer in violation of Maryland law but may also be a violation of the Mental Health Parity and Addiction Equity Act, which requires that any policies or procedures that limit access to mental health treatment be no applied no more stringently than those requirements applied to medical/surgical treatment.

I request that **[insert insurer]** authorize **[insert patient name]** to see an out of network provider at in-network cost-sharing as it is impossible at this time for me to wait for an appointment with the providers listed in the **[insert insurer]** directory. Also, I respectfully request MIA investigate whether the credentialing policies and procedures of **[insert insurer]** are in violation of the Mental Health Parity and Addiction Equity Act.

Sincerely

[name]

[SAMPLE Parity Complaint Letter PRIOR AUTHORIZATION]

[date]

[address]

[member number if applicable]

Ms. Mary Kwei, Chief, Complaints, Appeals and Grievances Division
Maryland Insurance Administration
2700 St. Paul St., Suite 2700
Baltimore, MD 21202

Ms. Kwei,

I am writing regarding [insert insurer/plan name] prior authorization requirement for behavioral health services (BHS). This letter serves to raise concerns of whether the application of this prior authorization requirement is in compliance with the Final Regulations established pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

[Insert paragraph describing the issue]

While MHPAEA does not prohibit the use of prior authorization, it does require that they be comparable to and no more stringent than what is applied to medical/surgical care. We are unaware of comparable requirements for this level of services for medical/surgical conditions.

The prior authorization requirement is a nonquantitative treatment limitation (NQTL) as defined in the final regulations. If the preauthorization requirements for [insert services] are not applied to similar levels of medical/surgical care in the same manner, then the above-described medical management protocol for BHS is a more stringent and non comparable application of an (NQTL) as defined by the Parity regulations (45 CFR 146.136c(4)) and is therefore noncompliant with MHPAEA. The rule governing NQTLs is as follows:

(4) Nonquantitative treatment limitations – (i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

[Insert insurer] has a prior authorization requirement for [insert services]. We are unable to determine whether insurer employs a similar prior authorization requirement for similar levels of medical/surgical care and whether these levels of care also require application of similar medical necessity criteria as we do not have access to the medical necessity criteria for medical/surgical care. The application of this prior authorization requirement may be in violation of the regulation's "comparable and no more stringently" standard and the "no separate treatment" limitation.

The regulations state clearly that any "processes, strategies, evidentiary standards, or other factors" used in applying a NQTL to BHS benefits in a classification must be "comparable to" and be applied "no more stringently" than the processes, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits. Given the aforementioned concerns, we have a number of questions and requests regarding whether this policy comports with the parity requirements. We request that MIA require [insert carrier] to provide documentation and required analysis to respond to the following questions:

- 1. Which covered health plan services for medical/surgical conditions have similar prior authorization requirements?**
- 2. What are the processes, strategies and evidentiary factors used to determine when and how to apply prior authorization to behavioral health services?**
- 3. What are the processes, strategies and evidentiary factors used to determine when and how to apply prior authorization for similar medical/surgical services?**
- 4. What analysis has been done to determine that the application of this prior authorization process is comparable and no more stringent than the prior authorization process for similar medical/surgical services?**

The Parity Statute clearly outlines the legal obligation regarding the medical necessity criteria disclosure requirements:

42 CFR 146.136(d)(1) Availability of plan information - (1) Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

Also ERISA regulations 29 CFR 2520.104b-1 outlines the legal obligation regarding the disclosure of plan documents. The Department of Labor issued guidance in December 2010 stating plan documents include the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits.

Finally, the Department of Labor has recently released a list of “red flags” or warning signs of nonquantitative treatment limitations that warrant further investigation to determine whether their application to a particular benefit is in compliance with the Federal Parity Law. You will note that prior authorization requirements are on the list, which can be obtained at this link.

<https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

Thank you for your time in investigating this matter.

[SAMPLE Parity Complaint Letter DENIAL OF AUTHORIZATION]

[date]

[address]

[member number if applicable]

Ms. Mary Kwei, Chief, Complaints, Appeals and Grievances Division
Maryland Insurance Administration
2700 St. Paul St., Suite 2700
Baltimore, MD 21202

Ms. Kwei,

I am writing regarding **[insert insurer/plan name]** utilization review requirement for all behavioral health services (BHS). This letter serves to raise concerns of whether the utilization review process employed by **[insert insurer]** which resulted in the denial of authorization for **[Insert service]** and application of the medical necessity criteria for **[insert service]** is in compliance with the Final Regulations established pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

[Insert paragraph describing the issue]

While MHPAEA does not prohibit the use of utilization review, it does require that the application of the utilization review process and criteria be comparable to and no more stringent than what is applied to medical/surgical care. We are unaware of comparable requirements for this level of services for medical/surgical conditions.

The utilization review requirement is a nonquantitative treatment limitation (NQTL) as defined in the final regulations. If the utilization review process for **[insert services]** are not applied to similar levels of medical/surgical care in the same manner, then the above-described medical management protocol for BHS is a more stringent and non comparable application of an (NQTL) as defined by the Parity regulations (45 CFR 146.136c(4)) and is therefore noncompliant with MHPAEA. The rule governing NQTLs is as follows:

(4) Nonquantitative treatment limitations – (i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

[Insert insurer] has a utilization review process for **[insert services]**. We are unable to determine whether insurer employs a similar utilization review process for similar levels of medical/surgical care; if so, how this requirement is applied; and what if any processes, strategies, factors, or evidentiary standards were used to develop and apply this requirement as we do not have access to the medical necessity criteria for medical/surgical care. The use and application of this process may be in violation of the regulation’s “comparable and no more stringently” standard and the “no separate treatment” limitation.

The regulations state clearly that any “processes, strategies, evidentiary standards, or other factors” used in applying a NQTL to BHS benefits in a classification must be “comparable to” and be applied “no more stringently” than the processes, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits. Given the aforementioned concerns, we have a number of questions and requests regarding whether this policy comports with the parity requirements. We request that MIA require **[insert carrier]** to provide documentation and required analysis to respond to the following questions:

- 1. Which covered health plan services for medical/surgical conditions have similar utilization review requirements?**
- 2. What are the processes, strategies, and evidentiary factors used to determine when and how to apply utilization review to behavioral health services?**
- 3. What analysis has been done to determine that the application of this utilization review process is comparable and no more stringent than the utilization review process for similar medical/surgical services?**
- 4. What are the processes, strategies, and evidentiary factors used to determine when and how to apply utilization review for similar medical/surgical services?**
- 5. What are the processes, strategies, and evidentiary factors used to develop the medical necessity criteria for behavioral health services?**
- 6. What are the processes, strategies, and evidentiary factors used to develop the medical necessity criteria for similar medical/surgical services?**
- 7. What analysis has been done to determine that the process used for development and application of the medical necessity criteria for behavioral health services is comparable and no more stringent than the process for development and application of medical necessity criteria for comparable medical/surgical services?**

The Parity Statute clearly outlines the legal obligation regarding the medical necessity criteria disclosure requirements:

42 CFR 146.136(d)(1) Availability of plan information - (1) Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

Also ERISA regulations 29 CFR 2520.104b-1 outlines the legal obligation regarding the disclosure of plan documents. The Department of Labor issued guidance in December 2010 stating plan documents include the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits.

Finally, the Department of Labor has recently released a list of “red flags” or warning signs of nonquantitative treatment limitations that warrant further investigation to determine whether their application to a particular benefit is in compliance with the federal parity law. You will note that authorization requirements are on the list, which can be obtained at this link.

<https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

Thank you for your time in investigating this matter.