

# Health Insurance for Addiction & Mental Health Care



**A Guide to the  
Federal Parity Law**



## ACKNOWLEDGEMENTS

This publication was made possible through the generous support of The New York Community Trust and the New York State Office of Alcoholism and Substance Abuse Services.

The Legal Action Center thanks the following individuals and organizations for their invaluable assistance with this project: Diane Spicer, Alexandra Berke, Mariyam Hussein, and Bailey Acevedo of the Community Service Society's Community Health Advocates; Ellen Weber of the University of Maryland School of Law; Amy Lowenstein of the Empire Justice Center; Rebecca Novick of the Legal Aid Society; Garry Carneal of the Kennedy Forum; Mary Beth Forshaw, Steven Halpern, Trevor Lawson, and Timothy Lobdell of Simpson Thacher & Bartlett LLP; Luke Butler, Timothy Clement, and Marcelo Fernandez-Viña of ParityTrack; Clare McGorrian of Health Law Advocates; Dilynn Roettker; Tom Fusco, Tammy Oliver, and Laura Dillon of the New York Department of Financial Services; Vallencia Lloyd, Hope Goldhaber, Jonathan Bick, and Susan Bentley of the New York Department of Health; Rob Kent and Trishia Allen of the New York State Office of Alcoholism and Substance Abuse Services; and Lisa Landau and Michael Reisman of the New York Office of the Attorney General's Health Care Bureau.

# About the Legal Action Center

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

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**SUPPLEMENT to**  
***Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law***  
May 2019

**Summary**

In 2016, the Legal Action Center published *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*. The guide covered both the federal parity law and New York laws providing additional rights for mental health (MH) and/or substance use disorder (SUD) insurance coverage. Since then, more rights have become available in New York. They include:

- **Prohibition on concurrent review and prior authorization during the first 14 days of inpatient SUD treatment and the first 14 outpatient SUD treatment visits.**
- **Prohibition on prior authorization for emergency supplies of SUD medications.**
- **Prohibition on prior authorization for Medicaid enrollees seeking access to certain SUD medications.**

The following updates supplement the New York State MH and SUD protections listed in Legal Action Center’s 2016 publication *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*. Note that some rights, as indicated below, will not be effective until **January 1, 2020**.

**Section 6 – Additional Protections under New York State Laws**

**Edits (page 29)**

- Paragraph two should be deleted. This supplement now explains laws passed in 2016 to combat the New York opioid crisis.

**Edits (page 30)**

**Minor edits have been made to the following paragraphs and are italicized below:**

- 8) Your plan is required to use LOCADTR 3.0 or another tool approved by the New York Office of Alcoholism and Substance Abuse Services (OASAS) when deciding what level of *SUD care* is appropriate for you (for example outpatient vs. inpatient care).<sup>1</sup>
- If you have a Medicaid Managed Care plan, your plan is required to use the LOCADTR 3.0 tool, developed by the New York Office of Alcoholism and Substance

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<sup>1</sup> N.Y. Ins. L. § 4902(a)(9); N.Y. Pub. Health L. § 4902(1)(i).

Abuse Services (OASAS), when determining which level of *SUD care* is appropriate for you.<sup>2</sup>

### **Additional New York State SUD Protections (effective through December 31, 2019)**

Please note that these protections do not apply to CHP, self-insured group plans, and/or New York State Medicaid (unless otherwise stated below).

#### **1. Required Coverage**

- Most insurers must cover unlimited medically necessary inpatient SUD treatment.<sup>3</sup>
- Most plans must cover all FDA-approved medications for detox or maintenance treatment of SUD.<sup>4</sup>
- Most plans must provide immediate access (without prior authorization) to a five-day emergency supply of SUD medications.<sup>5</sup>
- Medicaid Managed Care plans must cover court-ordered SUD treatment in a facility licensed or authorized by OASAS if they would otherwise cover this type of treatment.<sup>6</sup>

#### **2. Limits on Utilization Review**

- NYS Medicaid (managed care and fee-for-service) may not require prior authorization for prescriptions of either of the following preferred formulary versions of SUD detox or maintenance treatment medication: buprenorphine and injectable naltrexone.<sup>7</sup>
- Most plans may not require prior authorization for inpatient SUD treatment at an in-network OASAS-certified facility.<sup>8</sup> And, during the first 14 days of inpatient SUD treatment, most plans may not conduct concurrent review if the OASAS-authorized treatment facility is in-network and provides the insurer with certain information within 48 hours of the patient's admission.<sup>9</sup>
  - After 14 days, the plan may only deny treatment under specific circumstances.
  - If the plan denies treatment, patient is only responsible for the required co-pay, co-insurance, or deductible.
- Most plans may not require prior authorization for outpatient SUD treatment at an in-network OASAS-certified facility.<sup>10</sup> And, during the first 2 weeks (i.e. 14 visits) of continuous outpatient SUD treatment, most insurers may not conduct concurrent

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<sup>2</sup> See Level of Care for Alcohol and Drug Treatment Referral: A Client Placement Criteria System for Use in New York State (N.Y. Office of Alcoholism and Substance Abuse Servs., 2015), pp.4–5, available at <https://www.oasas.ny.gov/treatment/health/locadtr/documents/LOCADTRManual.pdf>.

<sup>3</sup> N.Y. Ins. L. § 3216(i)(30)(A).

<sup>4</sup> N.Y. Ins. L. § 3221(l)(7-a).

<sup>5</sup> N.Y. Ins. L. § 3221(l)(7-b)(A).

<sup>6</sup> N.Y. Soc. Servs. L. § 364-j(4)(r).

<sup>7</sup> N.Y. Pub. Health L. § 273(10); N.Y. Soc. Servs. L. § 364-j(26-b).

<sup>8</sup> N.Y. Ins. L. § 3216 (i)(30)(D).

<sup>9</sup> See *id.*

<sup>10</sup> N.Y. Ins. L. § 3216 (i)(31)(E).

review if the OASAS-certified treatment facility is in-network and provides the insurer with certain information within 48 hours of patient's admission.<sup>11</sup>

- After 14 days, insurer may only deny treatment under certain circumstances.
- If insurer denies treatment, patient is only responsible for the required co-pay, co-insurance, or deductible.

### **Additional New York State SUD/MH Protections (effective January 1, 2020)**

Please note that these protections will not apply to CHP, self-insured group plans, and/or New York State Medicaid (unless otherwise stated below).

#### **1. Limits on Utilization Review**

- Most plans may not require prior authorization for SUD medication that they include in their formularies.<sup>12</sup>
- For large group insurance, copays and coinsurance for an SUD/MH outpatient treatment must be equivalent to copays and coinsurance for a primary care office visit.<sup>13</sup>
- Most plans may only charge one copay/coinsurance per day for outpatient SUD treatment visits.<sup>14</sup>
- Most plans may not require prior authorization for inpatient SUD treatment at an in-network OASAS-authorized facility.<sup>15</sup> And, during the first 28 days of inpatient SUD treatment, most plans may not conduct concurrent review if the treatment facility is OASAS-authorized, in-network, and provides the insurer with required information within 2 business days of the patient's admission.<sup>16</sup>
  - After this time, the plan may only deny treatment under specific circumstances.
  - If the plan denies treatment, the patient is only responsible for the required co-pay, co-insurance, or deductible.
- Most plans may not require prior authorization for outpatient SUD treatment at an in-network OASAS-authorized facility.<sup>17</sup> And, during the first 28 visits to outpatient SUD treatment, most plans may not conduct concurrent review if the treatment facility is OASAS-authorized, in-network, and provides the insurer with required information within 2 business days of the patient's admission.<sup>18</sup>
  - After this time, the plan may only deny treatment under specific circumstances.
  - If the plan denies treatment, the patient is only responsible for the required co-pay, co-insurance, or deductible.
- Most insurers may not require prior authorization for minors (children under the age of 18 years old), who are entering inpatient psychiatric care.<sup>19</sup>

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<sup>11</sup> *See id.*

<sup>12</sup> N.Y. Ins. Law § 3216(i)(31-a).

<sup>13</sup> N.Y. Ins. Law § 3221(l)(5)(B).

<sup>14</sup> N.Y. Ins. Law § 3221(l)(7)(C-1).

<sup>15</sup> N.Y. Ins. Law § 3216(i)(30)(D).

<sup>16</sup> *See id.*

<sup>17</sup> N.Y. Ins. Law § 3216(i)(31)(E).

<sup>18</sup> *See id.*

<sup>19</sup> N.Y. Ins. Law § 3216(i)(35)(G).

- Most insurers may not conduct concurrent review during the first 14 days of a minor's inpatient psychiatric treatment if the treatment facility provides the required information to the insurer.<sup>20</sup>
- When determining coverage of mental health care, most insurers must use evidence-based and peer-reviewed clinical review criteria that the New York State Office of Mental Health has approved for this purpose.<sup>21</sup>

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<sup>20</sup> *Id.*

<sup>21</sup> N.Y. Ins. Law § 4902(a)(12); N.Y. Pub. Health L. § 4902(1)(j).



# 1 Introduction

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

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

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

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



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

# 2 Who Should Use This Guide?

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

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

This information can be confusing! If you have questions after using this guide, the Legal Action Center's free parity hotline for New York SUD treatment providers, advocates, and lawyers might be of help.

## 3

# Summary of the Federal Parity Law

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

## **A. Background on the Federal Parity Law**

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

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

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

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

## **B. The Federal Parity Law’s Main Requirements**

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

- 1) Plans may not have any separate [financial requirements](#) or [treatment limitations](#) that apply only to MH or SUD benefits.<sup>10</sup>

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

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

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



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

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

What does that mean?

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

applying to MH/SUD benefits are comparable to, and applied no more stringently than, the ones used in applying the NQTL to medical/surgical benefits in the classification.)<sup>12</sup>

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



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

- 3) Plans must provide out-of-network benefits for MH and SUD services if they are provided for medical and surgical services.<sup>13</sup>



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

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



#### **Example of Essential Health Benefits:**

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

- 4) Plans must disclose the following:

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

All of these requirements are discussed in more detail in [Section 4](#).

### **C. Different Rules for Different Types of Plans**

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

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

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

- 1) Plans that **large employers** (51 or more employees) provide to their employees.
- 2) Most plans that **small employers** (50 or fewer employees) provide to their employees, including those that were bought on the health insurance marketplace ([New York State of Health](#)) and many that were bought outside the marketplace.



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

- 3) **Individual** plans.
- 4) Some **Medicaid** plans, including all Medicaid managed care plans and Medicaid plans for the “expansion population” under the ACA (including Alternative Benefit Plans).
- 5) [Children’s Health Insurance Program \(CHIP\)](#) plans, known in New York as [Child Health Plus](#).
- 6) **State and local government** employer plans.



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

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



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

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



the federal parity statute, the U.S. Office of Personnel Management issued a letter directing them to comply with it.<sup>17</sup>

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

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

**A note about Child Health Plus plans:** The [final regulations](#), which explain in more detail how the federal parity law applies to Children’s Health Insurance Program (CHIP) plans, including New York’s Child Health Plus (CHP), say that if a state’s CHIP plan covers Early and Periodic Screening, Diagnostic, and

Treatment (known as [EPSDT](#)) in compliance with federal law, the CHIP plans will be presumed to comply with the federal parity law. Under these regulations, New York’s CHP plan would be presumed to comply with the federal parity law because it does cover EPSDT.<sup>21</sup> However, you may still report concerns about possible violations of the federal parity law by your CHP plan. See [Section 7](#) for more information about what to do if your plan may be violating the federal parity law.

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

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

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

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

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

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

# 4 The Federal Parity Law: The Details

## **A. Financial Requirements & Treatment Limitations**

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

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

Remember, the federal parity law says:

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

#### (i) **Classifications**

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

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

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

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

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

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



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

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

When comparing [financial requirements](#) or [treatment limitations](#) in the same [classification](#), you should compare them by [type](#) of financial requirement or treatment limitation.<sup>30</sup>

A [type](#) of financial requirement or treatment limitation means the nature of the financial requirement or treatment limitation. Different types of [financial limitations](#) include deductibles, co-payments, coinsurance, and out-of-pocket maximums. Different types of [quantitative treatment limitations](#) include annual limits, episode limits, and lifetime

day and visit limits. For examples of different types of [non-quantitative treatment limitations](#) (NQTLs), see the NQTL definition in the [Glossary](#).



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

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

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



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

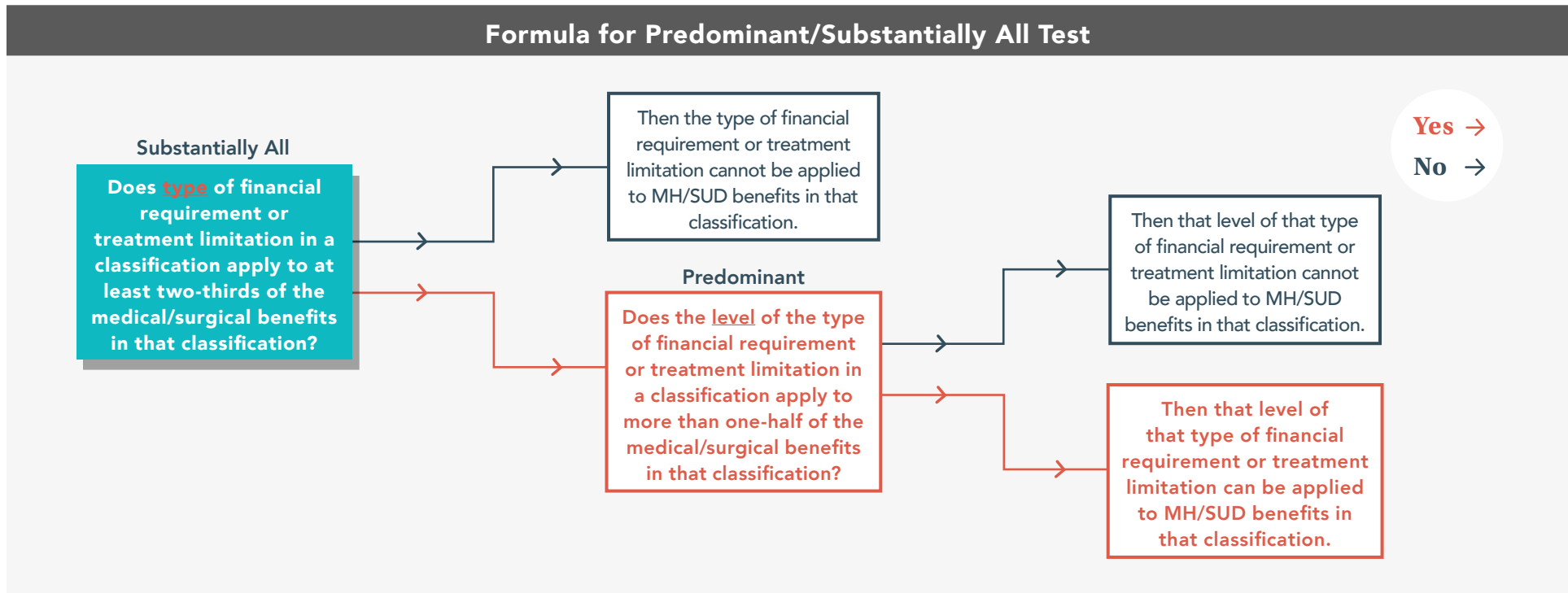
Your health plan may be violating the federal parity law. The plan offers MH/SUD benefits in the “outpatient, in-network” classification (which is how the plan classifies outpatient addiction counseling), but not in the “inpatient, in-network” **classification** (which is how the plan classifies inpatient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

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

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

- » Under the mathematical formula, a **type** of **financial requirement** or **quantitative treatment limitation** applies to **substantially all** medical/surgical benefits in a **classification** if it applies to at least *two-thirds* of those benefits. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then it cannot be applied to MH/SUD benefits in that classification.<sup>34</sup>
- » Once you have determined that a **type** of **financial requirement** or **treatment limitation** applies to **substantially all** (at least two-thirds) of the medical/surgical benefits in a **classification**, you must determine whether the **level** of that **type** of financial requirement is the **predominant** one. The level of a type of financial requirement or treatment limitation is predominant if it applies to more than *one-half* of the medical/surgical benefits in a classification.<sup>35</sup>

Therefore, the basic mathematical formula looks like this:



If you are interested in additional details about how the mathematical formula works, you can find them in the regulations.<sup>36</sup>

[Non-quantitative treatment limitations](#) are also subject to the “predominant/substantially all test.” However, unlike [financial requirements](#) and [quantitative treatment limitations](#), this test is not decided by a mathematical formula for *non-quantitative* treatment limitations. This is because *non-quantitative* treatment limitations are, as a rule, not expressed numerically. Instead, the regulations state that plans may not impose a non-quantitative treatment limitations on MH/SUD benefits unless any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment

limitation to MH/SUD benefits are comparable to, and applied no more stringently than, those used in applying the non-quantitative treatment limitation to medical/surgical benefits.<sup>37</sup> [Non-quantitative treatment limitations](#) are discussed in more detail in [Section iii](#), below.

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

Remember, there are two types of [treatment limitations](#) under the federal parity law:

- » [Quantitative treatment limitations](#), and
- » [Non-quantitative treatment limitations \(NQTs\)](#).



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

As with the [quantitative treatment limitations](#) (and [financial requirements](#)) discussed above, the federal parity law requires NQTLS to be applied comparably to MH/SUD benefits and medical/surgical benefits. Federal parity law prohibits health insurance plans from imposing a NQTL on MH/SUD benefits in any [classification](#) (see [Section \(i\)](#)), unless the plan's processes, strategies, evidentiary standards, and other processes used in applying the NQTL to MH/SUD benefits are comparable to, and applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in that classification.<sup>38</sup>

**The following examples are just some of the ways in which NQTLS do and do not violate the federal parity law.**

### Examples of Non-Quantitative Treatment Limitations



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

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



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

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



## Examples of Non-Quantitative Treatment Limitations



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

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



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

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

## Examples of Non-Quantitative Treatment Limitations



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

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



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

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

### (iv) Prescription drugs

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

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

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



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

(v) **Sub-classifications**

Plans are also permitted to create multiple tiers of in-network providers. For example, a plan could have an in-network tier of “preferred providers,” who are the least expensive, and an in-network tier of “participating providers,” who are more expensive. If a plan divides its in-network providers into multiple tiers, these tiers are considered **sub-classifications**, and the tiers must be based on reasonable factors such as quality, performance, or market standards. Tiers must be created without regard to whether a provider provides MH/SUD services or medical/surgical services. If a health plan establishes this type of sub-classification, it must then compare MH/SUD and medical/surgical benefits across *sub-classifications* (rather than classifications) to ensure that any **financial requirements** and **treatment limitations** imposed on MH/SUD benefits in that sub-classification are imposed no more restrictively than the **predominant** financial requirements and treatment limitations imposed on **substantially all** medical/surgical benefits in that

sub-classification.<sup>40</sup> (Note that this type of sub-classification doesn’t apply to Medicaid and CHIP plans. See [Section 4-A-i](#) for more information.)

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

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

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

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

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

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

**(vi) Cumulative financial requirements and treatment limitations**

The federal parity law also says private health insurance plans may not apply any [cumulative financial requirements](#) or [cumulative quantitative treatment limitations](#) to MH/SUD

benefits in a [classification](#) that accumulate separately from cumulative financial requirements and treatment limitations for medical/surgical benefits in that classification.<sup>43</sup> Medicaid and CHIP plans are also forbidden from applying separate cumulative financial requirements to MH/SUD and medical/surgical benefits. However, Medicaid and CHIP plans may apply separate cumulative quantitative treatment limitations to MH/SUD benefits and medical/surgical benefits.<sup>44</sup>

“[Cumulative financial requirements](#)” are [financial requirements](#) that determine whether or to what extent benefits are provided based on accumulated amounts. Examples include [deductibles](#) and [out-of-pocket maximums](#).

“[Cumulative quantitative treatment limitations](#)” are [treatment limitations](#) that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or life-time day or visit limits.



**Example 1 of Cumulative Financial Requirement:**

An employer-provided health plan imposes a combined annual \$500 deductible on all medical/surgical, MH, and SUD benefits.

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



### Example 2 of Cumulative Financial Requirement:

An employer-provided health plan imposes an annual \$250 deductible on all medical/surgical benefits and a separate annual \$250 [deductible](#) on all MH/SUD benefits.

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

## B. Disclosure & Transparency Requirements

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

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

Federal laws, including ERISA and the ACA, also require most health plans covered by the federal parity law to provide you

with the following information, upon request:

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

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

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

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

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

### C. Red Flags

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

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

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

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

# 5

# How To Determine Your Type of Health Insurance Plan

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

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

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

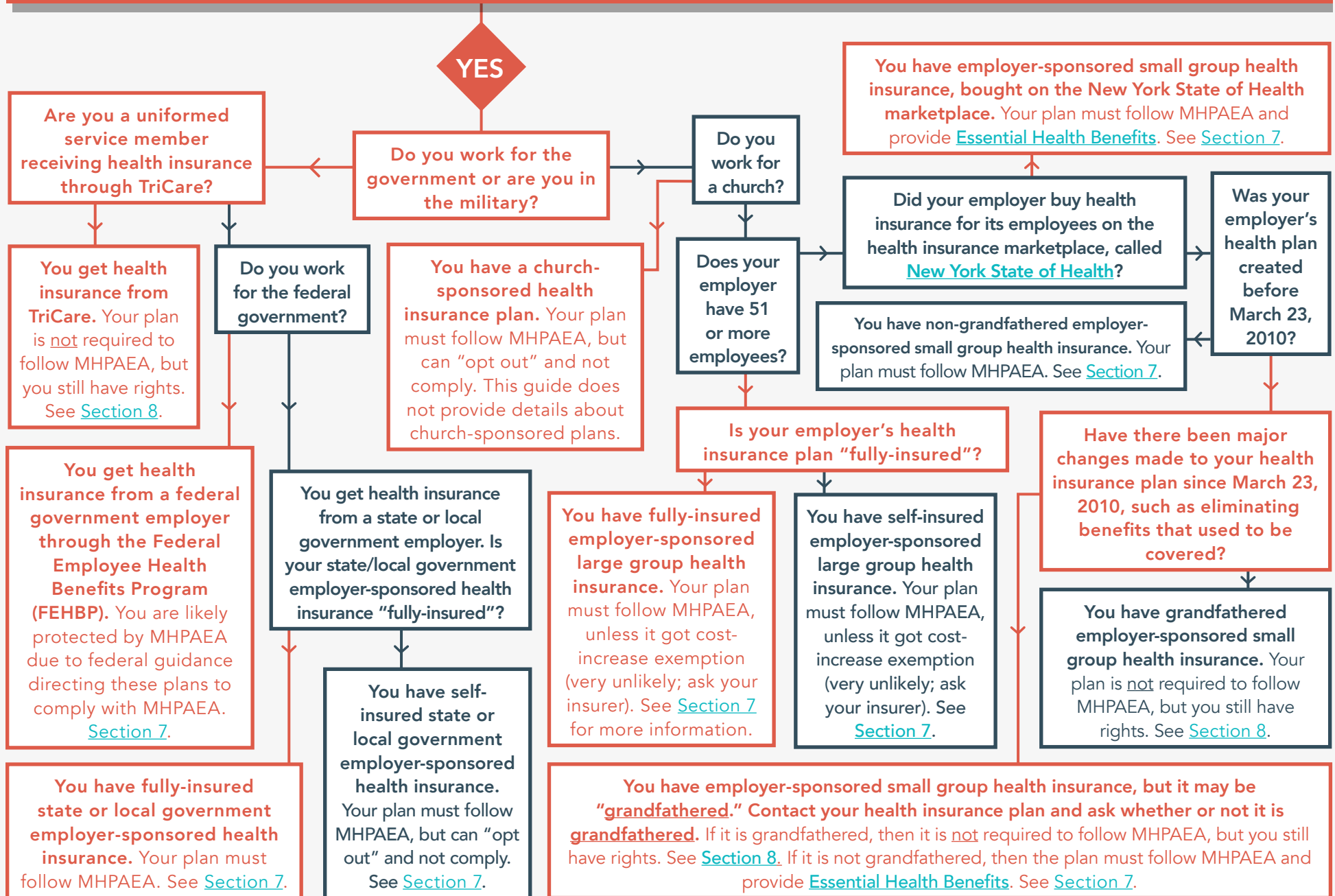
After learning what type of plan you have, find it in the [Key on page 28](#). Each plan has a corresponding color, shape, and number you can use to follow your plan throughout [Sections 6](#) and [7](#).



# Do you receive health insurance from your employer?

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

Yes →  
No →

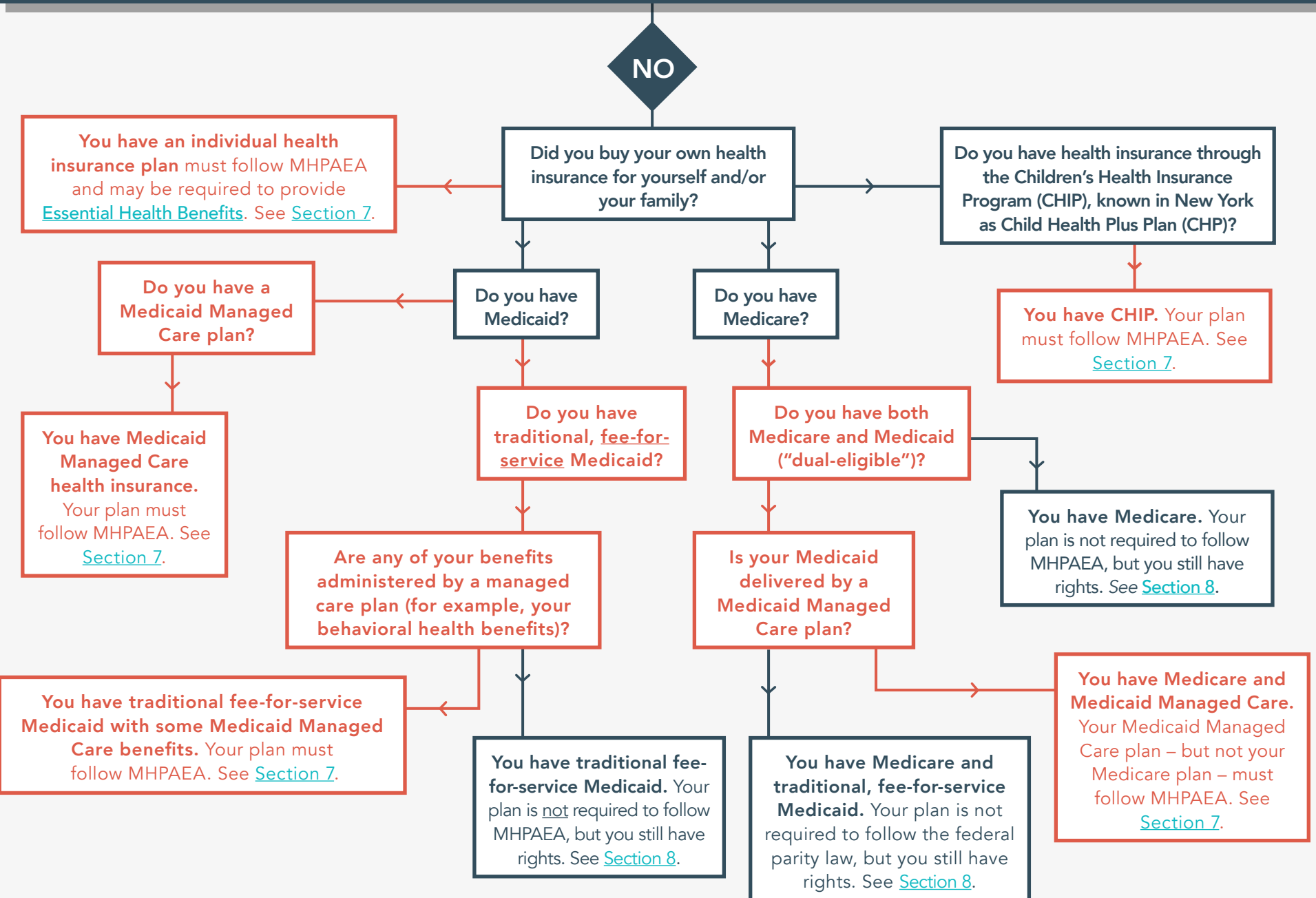




# Do you receive health insurance from your employer?

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

Yes →  
No →



Health Plan Key

# Health Plans In This Document

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

-  **1 Individual Plan**
-  **2 Small Group Plan Bought on Marketplace**

-  **3 Small Group Plan Not Bought on Marketplace, Non-Grandfathered**
-  **4 Fully-Insured Large Group Plan**
-  **5 Self-Insured Large Group Plan, Non-Grandfathered**
-  **6 Self-Insured Large Group Plan, Grandfathered**
-  **7 Federal Government Employer Plan**

-  **8 State or Local Government Employer Plan, Fully-Insured**
-  **9 State or Local Government Employer Plan, Self-Insured**
-  **10 Medicaid Managed Care Plan**
-  **11 Child Health Plus Plan**

# 6 Additional Protections Under New York State Laws

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

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

The protections described in this section apply to following types of health plans:<sup>53</sup>

## Plans Protected by Certain New York State Laws

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

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

- 1) Your health plan must cover both inpatient and outpatient diagnosis and treatment of substance use disorders, including detoxification and rehabilitation services, and must do so in compliance with the federal parity law.<sup>54</sup>
- 2) Family members of people receiving the inpatient and outpatient SUD services that plans are required by law to cover must be provided up to 20 outpatient visits per policy or calendar year.<sup>55</sup>
- 3) Your health plan must cover at least 30 days of inpatient mental health care and at least 20 days of outpatient mental health care.<sup>56</sup>
- 4) Your health plan is required to provide “broad based coverage for the diagnosis of mental, nervous or emotional disorders or ailments” that is at least equal to coverage provided for other health conditions.<sup>57</sup>
- 5) Your health plan must cover at least 30 days of inpatient mental health care and at least 20 days of outpatient mental health care.<sup>58</sup> Your health plan must provide coverage for adults and children with “biologically based mental illness”<sup>59</sup> and for children with “serious emotional disturbances”<sup>60</sup> that is comparable to the coverage it provides for other physician services and inpatient hospital care.<sup>61</sup>
- 6) Health plans that cover psychiatric or psychological services must reimburse for those services regardless of whether they are provided by a physician, psychiatrist, certified and registered psychologist, or licensed clinical social worker.<sup>62</sup>
- 7) If you submit a [claim](#) for inpatient SUD treatment at least 24 hours before being discharged from an inpatient admission, your health plan may not deny the [claim](#) on the basis of [medical necessity](#) or lack of prior authorization while the health plan’s determination about whether to provide coverage is pending.<sup>63</sup>
- 8) Your plan is required to use [LOCADTR 3.0](#) or another tool approved by the New York Office of Alcoholism and Substance Abuse Services (OASAS) when deciding what level of MH/SUD care is appropriate for you (for example, outpatient vs. inpatient care).<sup>64</sup>
- 9) Upon request, your plan must provide you with the clinical review criteria it used to make an [adverse benefit determination](#), as well as the specific written clinical review criteria relating to a particular condition or disease.<sup>65</sup>

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

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

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

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

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

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

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

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

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

- » Keep a list of every time you communicate with your health plan or a government agency (whether by phone, email, or mail). On the list, write the date of the communication, the name of the person you spoke to, and what the person you spoke to said.
- » Keep copies of all written communications with your health plan or government agencies, including: [internal appeals](#), [grievances](#), [external appeals/reviews](#), and complaints. Keep copies of both what you send to them and what they send to you.

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

## **A. Internal Appeal**

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

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

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

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

## Additional Internal Appeal Rights

1

### Individual Plan<sup>71</sup>

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

---

10

### Medicaid Managed Care Plan<sup>72</sup>

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

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

11

### Child Health Plus Plan<sup>73</sup>

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

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

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



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

## How Long You Have to FILE Internal Appeal

1

### Individual Plan<sup>75</sup>

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

2

### Small Group Plan Bought on Marketplace<sup>76</sup>

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

3

### Small Group Plan Not Bought on Marketplace, Non-Grandfathered<sup>77</sup>

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

4

### Fully-Insured Large Group Plan<sup>78</sup>

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

5

### Self-Insured Large Group Plan, Non-Grandfathered<sup>79</sup>

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

6

### Self-Insured Large Group Plan, Grandfathered<sup>80</sup>

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

7

### Federal Government Employer Plan<sup>81</sup>

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

8

### State or Local Government Employer Plan, Fully-Insured<sup>82</sup>

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

9

### State or Local Government Employer Plan, Self-Insured<sup>83</sup>

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

10

### Medicaid Managed Care Plan<sup>84</sup>

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

11

### Child Health Plus Plan<sup>85</sup>

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



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

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



## How Long Your Plan Has to DECIDE Your Internal Appeal

1

### Individual Plan<sup>86</sup>

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

2

### Small Group Plan Bought on Marketplace<sup>87</sup>

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

3

### Small Group Plan Not Bought on Marketplace, Non-Grandfathered<sup>88</sup>

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

4

### Fully-Insured Large Group Plan<sup>89</sup>

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

5

### Self-Insured Large Group Plan, Non-Grandfathered<sup>90</sup>

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

6

### Self-Insured Large Group Plan, Grandfathered<sup>91</sup>

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

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

7

### Federal Government Employer Plan<sup>92</sup>

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

8

### State or Local Government Employer Plan, Fully-Insured<sup>93</sup>

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

9

### State or Local Government Employer Plan, Self-Insured<sup>94</sup>

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

10

### Medicaid Managed Care Plan<sup>95</sup>

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

11

### Child Health Plus Plan<sup>96</sup>

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

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

## Expedited Internal Appeal Rights

### 1

#### Individual Plan<sup>97</sup>

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

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

### 2

#### Small Group Plan Bought on Marketplace<sup>98</sup>

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

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

CONTINUED ON NEXT PAGE

## Expedited Internal Appeal Rights Continued

3

### Small Group Plan Not Bought on Marketplace, Non-Grandfathered<sup>99</sup>

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

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

5

### Self-Insured Large Group Plan, Non-Grandfathered<sup>101</sup>

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

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

4

### Fully-Insured Large Group Plan<sup>100</sup>

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

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

6

### Self-Insured Large Group Plan, Grandfathered<sup>102</sup>

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

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

CONTINUED ON NEXT PAGE

## Expedited Internal Appeal Rights Continued

7

### Federal Government Employer Plan

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

8

### State or Local Government Employer Plan, Fully-Insured<sup>103</sup>

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

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

9

### State or Local Government Employer Plan, Self-Insured<sup>104</sup>

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

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

10

### Medicaid Managed Care Plan<sup>105</sup>

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

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

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

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

**REMEMBER:** You can also request a [fair hearing](#) without going through the appeal process first.

11

### Child Health Plus Plan<sup>106</sup>

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

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

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

When your plan makes a decision about your [internal appeal](#), it must notify you in writing. This notification must explain the reason for the plan's decision and provide you with information about any [external appeal/review](#) rights you have.<sup>127</sup> If you have a large or small group plan or an individual plan, and your plan upholds its [adverse benefit determination](#) on appeal, it must also provide you with the following: reference to the specific plan provisions on which the [adverse benefit determination](#) is based; free copies, upon request, of all documents, records, and other information relevant to your [claim](#) for benefits; and, if the

[adverse benefit determination](#) was based on [medical necessity](#) or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances.<sup>109</sup>

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

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

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

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

## B. External Appeal

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

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

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

### (i) Internal Appeal, Adverse Benefit Determination Upheld

You may have the right to an [external appeal/review](#) if you file an [internal appeal](#) and your plan upholds its [adverse benefit determination](#) based on the plan's medical judgment. This includes [adverse benefit determinations](#) where the plan says the services you requested: are not [medically necessary](#); do

not meet the plan's requirements for appropriateness, health care setting, level of care, or effectiveness; are experimental or investigational; or are out-of-network and an alternate recommended treatment or provider is available in-network.<sup>118</sup> Final regulations implementing appeal rights under the ACA also make clear that most people have the right to request an [external appeal/review](#) of a plan's determination that it complies with the federal parity law's [non-quantitative treatment limitation](#) requirements.<sup>119</sup>

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

### Plans With External Appeal Rights After Denial Upheld

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



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

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

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

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

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

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



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

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

## Plans That May Not Charge Fee For External Appeal/Review

5

**Self-Insured Large Group Plan, Non-Grandfathered**<sup>138</sup>

10

**Medicaid Managed Care Plan**

11

**Child Health Plus Plan**<sup>139</sup>

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

### External Appeals Not Decided by DFS

5

**Self-Insured Large Group Plan, Non-Grandfathered**<sup>141</sup>

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

7

**Federal Government Employer Plan**<sup>142</sup>

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

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

- » **Medical Necessity Denial:** If the external appeal agent is conducting an [external appeal/review](#) because your health plan said the service you requested or received was not [medically necessary](#), the agent must overturn your plan's denial if the agent determines your plan did not act reasonably, with sound medical judgment, and in the patient's best interest. When reviewing medical necessity denials, external appeal agents must consider the following additional information: applicable and generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards, and associations.<sup>144</sup>
- » **Experimental/Investigational Denial:** If the external appeal agent is conducting an [external appeal/review](#) because your health plan said the service you requested or received is experimental or investigational, the agent must overturn your plan's denial if the agent determines: the requested service is likely to be more beneficial than any standard treatment for the patient's condition or disease; the requested service is likely to benefit the patient; and the benefit of the requested service to the patient outweighs the service's risks. When reviewing experimental/investigational denials, external appeal agents must consider the following additional information:



the applicable medical and scientific evidence; any evidence presented by the patient, the patient's designee, or the patient's physician; the patient's medical record; and any other pertinent information.<sup>145</sup>

- » **Out-of-Network Service Denial:** If the external appeal agent is conducting an [external appeal/review](#) because the service you requested or received is out-of-network, and your plan denied the service on the grounds that an alternate recommended treatment is available in-network, the agent must overturn the plan's denial if it determines: the out-of-network service is likely to be more clinically beneficial than the alternate recommended in-network service; and the risk of the out-of-network service would not be substantially greater than the risk of the in-network service. When reviewing out-of-network service denials, external appeal agents must consider the following additional information: the applicable medical and scientific evidence; the patient's medical record, and any other pertinent information that the out-of-network service is likely to be more beneficial and would not substantially increase risk to the patient.<sup>146</sup>
- » **Out-of-Network Referral Denial:** If the external appeal agent is conducting an [external appeal/review](#) because your out-of-network referral was denied by your plan on the grounds that the plan has an in-network provider with appropriate training and experience to meet the patient's needs and is able to provide the requested service, the external appeal agent must overturn the plan's denial if the agent determines: the health plan does not have a provider with the appropriate training and experience to meet the patient's needs and who is able to provide

the requested service; the out-of-network provider does have the appropriate training and experience to meet the patient's needs and is able to provide the requested service; and the out-of-network provider is likely to produce a more clinically beneficial outcome. When reviewing out-of-network referral denials, external appeal agents must consider the following additional information: the training and experience of both the requested out-of-network provider and the recommended in-network provider; the patient's medical record; and any other pertinent information.<sup>147</sup>

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

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

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

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

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

**If you need help,** [Community Service Society’s Community Health Advocates](#) (“CHA”) is New York State’s designated

Consumer Assistance Program under the Affordable Care Act. You can contact CHA for assistance with things like filing appeals by visiting [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org) or calling CHA’s toll-free hotline at 1-888-614-5400.

### C. Grievance

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

#### Plans With Grievance Rights

1

**Individual Plan**<sup>155</sup>

3

**Small Group Plan Not Bought on Marketplace, Non-Grandfathered**<sup>157</sup>

10

**Medicaid Managed Care Plan**<sup>160</sup>

2

**Small Group Plan Bought on Marketplace**<sup>156</sup>

4

**Fully-Insured Large Group Plan**<sup>158</sup>

11

**Child Health Plus Plan**<sup>161</sup>

9

**State or Local Government Employer Plan, Self-Insured**<sup>159</sup>

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

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



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

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

## D. Fair Hearing—Medicaid Only

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

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

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

You can request a [fair hearing](#) when:

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

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

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

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

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

If you request a [fair hearing](#), the hearing must be held at a reasonable time, date, and place, and you must receive adequate written notice of where and when the hearing will be held. You may receive priority in scheduling your [fair hearing](#) and receiving a decision from the judge if you have an **urgent**



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

need for medical care.<sup>172</sup> Otherwise, the state has **90 days** after your [fair hearing](#) to issue a written decision. If the [fair hearing](#) decision is not in your favor, you will also receive notice of your right to ask a state court judge to review the decision.<sup>173</sup> The [fair hearing](#) decision is binding, and will take precedence over decisions made in response to any appeals and/or grievances you have filed.

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

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

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

## **E. Complaint to Government Agency**

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

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

Each of these options is explained in more detail below.

### ***(i) Agencies Tasked with Enforcement***

The federal government agencies tasked with enforcing the federal parity law have delegated primary enforcement authority to the states. This means that you generally should file a complaint with the state government before filing a complaint with the federal government. (Note that if you have a federal government plan, there are no government agencies specifically tasked with

enforcing your parity rights. If you have already gone through your internal and external appeals, you can complain to OPM or file a lawsuit (see [Section 7-F](#).)

### **(a) State Government Agencies**

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

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

### **Complaints to DFS:**

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

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

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

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

Remember to save all documents and correspondence related to any complaints you file. See [Section 12](#) for a

sample complaint regarding possible violations of the federal parity law.

### **Complaints to DOH:**

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

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

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

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

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



(b) **Federal Government Agencies**

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

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

**Complaints to HHS:**

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

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

**Complaints to DOL:**

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

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

\* These plans can also complain to the Treasury.

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

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

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

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

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

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

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

## **F. Lawsuit**

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



# 8 Plans That Are Not Covered by the Federal Parity Law

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

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

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

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

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

- » [Self-insured](#) state and local government plans;
- » Church-sponsored plans; and
- » Plans that have successfully applied for a cost increase exemption.

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

# 9 Glossary

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

**Adverse Benefit Determination:** Adverse benefit determination means slightly different things depending on what type of plan you have. For large and small group plans and individual plans, an adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a

participant’s or beneficiary’s eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not [medically necessary](#) or appropriate.<sup>179</sup> For some plans, an adverse benefit determination also includes any [rescission](#) of coverage.<sup>180</sup> With regard to individual health plans, an adverse benefit determination also includes any decision to deny coverage in an initial eligibility determination.<sup>181</sup> Medicaid plans use the term “[action](#)” rather than “adverse benefit determination.” See the definition of “[action](#)” above.

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

**Aggregate Lifetime Limit:** A dollar limitation on the total amount that may be paid by a plan toward an individual's benefits under the plan.<sup>183</sup>

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

**Appeal:** A request that your health plan review or reconsider its denial of coverage or payment.<sup>185</sup>

**Claim:** A request for coverage. A patient or health care provider will usually file a claim to be reimbursed for the costs of treatment or services.<sup>186</sup>

**Classification:** Under the federal parity law, all of a health insurance plan's benefits—mental health, substance use disorder, and medical/surgical—must be placed into one of six classifications: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.<sup>187</sup> For CHIP and Medicaid plans that are covered by the federal parity law, all of a plan's benefits must be placed into one of four classifications: (1) inpatient; (2) outpatient; (3) emergency care; and (4) prescription drugs.<sup>188</sup> Plans may also choose to create two kinds of [sub-classifications](#). See the definition of [sub-classification](#) for more information.

**Co-Insurance:** A percentage of the cost of a health care service that you pay, after you have paid any [deductible](#).<sup>189</sup>

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

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

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

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

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

**Expedited Appeal:** An appeal that gets decided more quickly by the reviewer, generally because the patient's health needs are urgent.<sup>195</sup>

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

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

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

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

**Fee for Service:** A health care delivery system where providers are paid for each service (like an office visit, test, or procedure).<sup>199</sup>

**Financial Requirements:** Includes [deductibles](#), [co-payments](#), [co-insurance](#), and out-of-pocket expenses; does not include annual limits and aggregate lifetime limits.<sup>200</sup>

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

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

**Grievance:** A complaint to a health plan to express dissatisfaction with something the plan has done does other than an [adverse benefit determination](#) or [action](#).<sup>202</sup>

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

**Internal Appeal:** A request for your health insurer or plan to review a decision or [grievance](#) again.<sup>203</sup>

**Large Group Plan:** Under the federal parity law, a large group plan is one provided by an employer with 51 or more employees.<sup>204</sup>

**Level** (of a [type](#) of [financial requirement](#) or [treatment limitation](#)): The magnitude of a [type](#) of [financial requirement](#) or [treatment](#)

**limitation.** For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include \$15 and \$20; different levels of a **deductible** include \$250 and \$500; different levels of an episode limit include 21 inpatient days per episode or 30 inpatient days per episode.<sup>205</sup>

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

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

**Medical or Surgical Benefits:** Means benefits with respect to medical or surgical services, as defined under the terms of the plan or, for Medicaid and CHIP, by the State; does not include MH or SUD benefits.<sup>208</sup> The health plan’s or State’s decision to define a condition as a medical/surgical condition (or not a medical/surgical condition) must be consistent with generally

recognized independent standards of current medical practice (such as the International Classification of Diseases (ICD), or state guidelines).<sup>209</sup>

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

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

**Network:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.<sup>213</sup>

**Non-Grandfathered:** Plans that are not **grandfathered**.

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

treatment; and restrictions based on geographic location, facility type, or provider specialty.<sup>214</sup>

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

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

**Quantitative Treatment Limitations:** [Treatment limitations](#) that are expressed numerically, such as limits on the number of days or visits or limits on the frequency of treatment.<sup>221</sup>

**Rescission:** A cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats

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

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

**Small Group Plan:** Under the federal parity law, a small group plan is one provided by an employer with 50 or fewer employees.<sup>223</sup>

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



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

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

**Substantially All:** At least two-thirds of all medical/surgical benefits in a [classification](#) of benefits.<sup>228</sup>

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

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

**Utilization Review:** A health plan’s review to determine whether health care services are [medically necessary](#).<sup>232</sup>





# 10 Appendix: Other Rights

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

1

## Individual Plan

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

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

2

## Small Group Plan Bought on Marketplace

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

- » ERISA regulations require health plans covered by ERISA to follow their own written rules.
- » The ACA requires this type of plan to offer Essential Health Benefits, which include MH and SUD benefits.
- » The ACA forbids this type of plan from designing or managing its essential benefits package in a way that limits coverage for people with disabilities, including people with MH/SUD.
- » The ACA requires this type of plan's benefits to address the health care needs of diverse segments of the population, including people with disabilities such as MH/SUD.

3

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

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

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

4

## Fully-Insured Large Group Plan

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

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

5

## Self-Insured Large Group Plan, Non-Grandfathered

You are protected by ERISA and potentially the ACA.

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

6

## Self-Insured Large Group Plan, Grandfathered

You are protected by ERISA.

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

7

## Federal Government Employer Plan

You can ask the [U.S. Office of Personnel Management](#) what additional rights you may have.

8

## State or Local Government Employer Plan, Fully-Insured

You are protected by the New York State laws described in [Section 6](#).

10

## Medicaid Managed Care Plan

You are protected by state and federal law.

- » You have the right to a fair hearing and **aid continuing**. See [Section 7-D](#) for more information.
- » Your plan is required to use [LOCADTR 3.0](#), developed by the New York Office of Alcoholism and Substance Abuse Services, to make level of care determinations for SUD services.
- » Your plan must cover inpatient and outpatient MH and SUD services.
- » Your plan is required by state law (in addition to the federal parity law) to provide you with an adequate network. See, e.g., N.Y. Soc. Serv. L. § 364-j(2)(c)(i).
- » Your plan must use a broader definition of "**medical necessity**" when deciding whether to cover services for you. For Medicaid Managed Care plans, a service is medically necessary if a patient needs it to prevent, diagnose, correct or cure conditions that: cause him/her suffering, endanger his/her life, result in illness or infirmity, interfere with his/her capacity for normal activity, or threaten a significant disability. See N.Y. Soc. Serv. L. § 365-a(2); see also CHA Advocates Guide p. 136.

## 11

## Endnotes

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

- [the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act.](#)
8. The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (Mar. 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440, 456, et al.), <https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>.
  9. 29 U.S.C. § 1185a(a)(3); 26 U.S.C. § 9812(a)(3); 42 U.S.C. § 300gg-26(a)(3).
  10. 29 U.S.C. § 1185a(a)(3); 26 U.S.C. § 9812(a)(3); 42 U.S.C. § 300gg-26(a)(3).
  11. See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68245.
  12. Note that the final regulations implementing the federal parity law also provide guidance on how to determine the predominant level of a financial requirement or treatment limitation if no one level applies to more than one-half of the medical/surgical benefits in a classification.
  13. 29 U.S.C. § 1185a(a); 42 U.S.C. § 300gg-26(a)(3); 26 U.S.C. § 9812(a).
  14. See, e.g., Ctr. for Consumer Info. & Insurance Oversight, Information on Essential Health Benefits Benchmark Plans, <https://www.cms.gov/cciiio/resources/data-resources/ehb.html>.
  15. See NY Dep’t of Fin. Servs., Accident & Health Product Filing, Model Language, Mental Health & Substance Use (Apr. 24, 2015), [http://www.dfs.ny.gov/insurance/health/model\\_lang\\_indx.htm](http://www.dfs.ny.gov/insurance/health/model_lang_indx.htm); Ctrs. for Medicare & Medicaid Servs., 2014 – 2016 Summary of EHB Benchmark Plan Benefits, Limits, & Prescription Drug Coverage, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-New-York-Benchmark-Summary.pdf>; see also, Ctrs. for Medicare & Medicaid Servs., State-Required Benefits, [https://downloads.cms.gov/cciiio/State%20Required%20Benefits\\_NY.PDF](https://downloads.cms.gov/cciiio/State%20Required%20Benefits_NY.PDF).
  16. See, e.g., 29 U.S.C. § 1185a(a)(4); 42 U.S.C. § 300gg-25(a)(4); 26 U.S.C. § 9812(a)(4); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239, 68274 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).
  17. FEHB Program Carrier Letter, Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equity Act of 2008 – Federal Employees Health Benefits Program Carrier Guidance, Letter No. 2008-17 (Nov. 10, 2008), <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf>.
  18. See, e.g., N.Y. Dep’t of Health, A Plan to Transform the Empire State’s Medicaid Program, [https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrtfinalreport.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf); N.Y. Dep’t of Health, MRT Managed Care Benefit & Population Expansion (Sept. 30, 2015), [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrt1458\\_timeline.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt1458_timeline.pdf).
  19. See N.Y. Dep’t of Health, Behavioral Health Transition to Managed Care, [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health).
  20. See 42 C.F.R. § 438.920(a); The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (Mar. 30, 2016).
  21. See The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18404 (Mar. 30, 2016).
  22. Although TRICARE plans are not required to follow the federal parity law, the Department of Defense released proposed regulations in February 2016 that aim to bring TRICARE plans into compliance with parity. See TRICARE; Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 5061 (Feb. 1, 2016) (to be codified at 32 C.F.R. pt. 199), <https://www.federalregister.gov/>

- [articles/2016/02/01/2016-01703/tricare-mental-health-and-substance-use-disorder-treatment](https://www.federalregister.gov/articles/2016/02/01/2016-01703/tricare-mental-health-and-substance-use-disorder-treatment).
23. Parity in Mental Health and Substance Use, 29 C.F.R. § 2590.712(g); Parity in Mental Health and Substance Use Disorder Benefits, 26 C.F.R. § 54.9812-1; Internal Claims and Appeals and External Review Processes, 45 C.F.R. § 147.136. Note that health insurance plans that qualify for the increased cost exemption and choose to implement it must notify plan participants and beneficiaries. See 29 C.F.R. § 2590.712(g)(6).
  24. For a list of state and local government plans that have opted out of the federal parity law, see HIPAA Opt-Out Elections for Self-Funded, Non-Federal Governmental Plans, <http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa-nfpg-list-7-9-2013.pdf>.
  25. See TRICARE; Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 5061 (Feb. 1, 2016) (to be codified at 32 C.F.R. pt. 199).
  26. See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146, 147).
  27. See 29 C.F.R. § 2590.712(c)(2)(i); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
  28. See The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389, 18395 (Mar. 30, 2016) (to be codified at 42 C.F.R. pts. 438, 440, 456, et al.); see also Medicaid & Children’s Health Insurance Programs; Mental Health Parity & Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans; Proposed Rule, 80 Fed. Reg. 19417, 19424 (Apr. 10, 2015) (to be codified at 42 C.F.R. pts. 438, 440, 456, et al.).
  29. See 29 C.F.R. § 2590.712(c)(2).
  30. *Id.*
  31. 29 C.F.R. § 2590.712(c)(2)(ii)(A); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
  32. 29 C.F.R. § 2590.712(c)(2)(ii)(B); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
  33. See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 at 68243; 29 C.F.R. § 2590.712(c)(3); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
  34. See 29 C.F.R. § 2590.712(c)(3)(i)(A); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
  35. See 29 C.F.R. § 2590.712(c)(3)(i)(B); 26 C.F.R. § 54.9812-1; 45 C.F.R. § 147.136.
  36. See 29 C.F.R. § 2590.712(c)(3); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 438.910, 457.496, 440.395.
  37. See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 at 68245; The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 at 18399; 29 C.F.R. § 2590.712(c)(4)(i); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 438.910, 457.496, 440.395.
  38. 29 C.F.R. § 2590.712(c)(4); 26 C.F.R. § 54.9812-1; 42 C.F.R. § 438.910. Note, however, that the regulations applying the federal parity law to Medicaid and CHIP allow quantitative [treatment limitations](#) (though not [financial requirements](#)) to accumulate separately for MH/SUD and medical/surgical benefits. See The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 at 18398-18399.
  39. 29 C.F.R. § 2590.712(c)(3)(iii); 26 C.F.R. § 54.9812-1; 42 C.F.R. §§ 483.910, 457.496, 440.395.



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

58. See N.Y. Ins. Law §§ 3221(l)(5)(A)(i), 4303(g). Note that this requirement applies to health insurance plans that cover inpatient hospital care or that cover physician services. *Id.*
59. “Biologically based mental illness” means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Examples include schizophrenia, psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia. N.Y. Ins. Law §§ 3221(l)(5)(B)(ii); 4303(g)(2)(B).
60. “Children with serious emotional disturbances” means people under the age of 18 who have been diagnosed with attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and who also have one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household. N.Y. Ins. Law §§ 3221(l)(5)(C), 4303(g)(3).
61. See N.Y. Ins. Law §§ 3221(l)(5)(B); 4303(g)(2).
62. See N.Y. Ins. Law §§ 3216(i)(4), 3221(l)(4)(A), 3221(l)(4)(D); see also Letter from OASAS, <https://www.oasas.ny.gov/regs/documents/InsReimbforCASACServices.pdf>.
63. See N.Y. Ins. Law § 4903(c)(3); see also N.Y. Ins. Law § 4904(b).
64. See NY Dep’t of Fin. Servs., Insurance Circular Letter No. 6 (2015) (Mar. 30, 2015), [http://www.dfs.ny.gov/insurance/circltr/2015/cl2015\\_06.htm](http://www.dfs.ny.gov/insurance/circltr/2015/cl2015_06.htm); see also March 11, 2015: OASAS: Level of Care Tools Used By Insurers for SUD, Post to 2015 State Agency News, N.Y. Council for Community Behavioral Healthcare (Mar. 11, 2015), <http://www.nyscouncil.org/state-agency-news>; see also April 28, 2015: OASAS Level of Care Tool, Post to 2015 State Agency News, N.Y. Council for Community Behavioral Healthcare (Apr. 28, 2015), <http://www.nyscouncil.org/state-agency-news>.
65. See N.Y. Ins. L. §§ 4903(e)(3), 3217-a(b)(10), 4324(b)(10); N.Y. Pub. Health L. §§ 4903(5)(c), 4408(2)(j); NY Dep’t of Fin. Servs., Insurance Circular Letter No. 6 (2015) (Mar. 30, 2015), [http://www.dfs.ny.gov/insurance/circltr/2015/cl2015\\_06.htm](http://www.dfs.ny.gov/insurance/circltr/2015/cl2015_06.htm).
66. Telephone interview with Tom Fusco, Supervising Insurance Attorney, N.Y. Dep’t of Fin. Servs., & Tammy Oliver, Associate Insurance Examiner, N.Y. Dep’t of Fin. Servs. (Feb. 26, 2016).
67. See Transitioning Behavioral Health Services Into NYC Medicaid Managed Care SUD Statutory; Regulatory; and Contractual Provisions, N.Y. Office of Alcoholism & Substance Abuse Servs., p. 2, <https://www.oasas.ny.gov/ManCare/documents/OASASMMCGuidance.pdf>; see also March 11, 2015: OASAS: Level of Care Tools Used By Insurers for SUD, Post to 2015 State Agency News, N.Y. Council for Community Behavioral Healthcare (Mar. 11, 2015), <http://www.nyscouncil.org/state-agency-news>.
68. See Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. 72192, 72206-72211 (Nov. 18, 2015) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 144, 146, and 147); 29 C.F.R. §§ 2590.715-2719, 2560.503-1(b)(4), (h); 45 C.F.R. § 147.136; 42 U.S.C. § 300gg-19; N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; 42 C.F.R. §§ 438.400 et seq.; N.Y. Soc. Serv. L. §§ 22(3)-(5), 364-j(9); N.Y. Dep’t of Health, Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract (Mar. 1, 2014), [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf); Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules, 80 Fed. Reg. 31908 (Jun. 1, 2015) (to be codified at 42 C.F.R. pts. 431, 433, 438 et al.); 5 C.F.R. § 890.105; see also Samuel C. Salganik, “Health Plan Appeal Rights



- in New York After the Affordable Care Act,” NYSBA Health Law Journal, Vol. 17 No. 1 (Winter 2012), <http://www.wnylc.com/health/afile/170/331>; Empire Justice Center, Child Health Plus in New York: A Program Primer, <http://www.wnylc.com/health/entry/93>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43330 (proposed Jul. 23, 2010) (to be codified at 26 C.F.R. pts. 54 & 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147); Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37208 (proposed Jun. 24, 2011) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147); Claims Procedure for Plans Providing Disability Benefits, 80 Fed. Reg. 72014 (proposed Nov. 18, 2015) (to be codified at 29 C.F.R. pt. 2560); MaryBeth Musumeci, A Guide to the Medicaid Appeals Process (The Henry J. Kaiser Family Foundation, March 2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>; N.Y. Dep’t of Health, “New York State Managed Care Model Member Handbook – Revised for 2010,” [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_model\\_member\\_handbook.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_model_member_handbook.pdf).
69. See 29 C.F.R. §§ 2560.503-1(h), (m)(4), 2590.715-2719(b); N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; 5 C.F.R. § 890.105; see also Salganik, *supra* note 61, at 34.
70. See 75 Fed. Reg. 43330, 43332; 80 Fed. Reg. 72192, 72207; [Healthcare.gov](http://www.healthcare.gov), Internal Appeals, <https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals>; N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; see also Salganik, *supra* note 61, at 36.
71. 80 Fed. Reg. 72192, 72207.
72. See 42 C.F.R. § 438.400(b); N.Y. Soc. Serv. L. §§ 22(3)-(5), 364-j(9); see also N.Y. Dep’t of Health, “Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract” (Mar. 1, 2014), available at [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf); MaryBeth Musumeci, A Guide to the Medicaid Appeals Process (The Henry J. Kaiser Family Foundation, March 2012), p. 21, available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.
73. See 42 C.F.R. §§ 457.1130(b); N.Y. Pub. Health L. §§ 4904, 4900; see also Empire Justice Center, “Child Health Plus in New York: A Program Primer,” available at <http://www.wnylc.com/health/entry/93>.
74. See 29 C.F.R. § 2560.503-1(h), (m)(4); N.Y. Ins. L. § 4904; N.Y. Pub. Health L. § 4904; 42 C.F.R. § 438.404.
75. See 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(3); 80 Fed. Reg. 72192; N.Y. Ins. L. § 4904(c).
76. See 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
77. See 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
78. See 29 C.F.R. § 2560.503-1(h)(3)(i).
79. *Id.*
80. *Id.*
81. See 5 C.F.R. § 890.105.
82. See N.Y. Ins. L. § 4904(c).
83. See N.Y. Ins. L. § 4904(c).
84. N.Y. Dep’t of Health, “Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract” (Mar. 1, 2014), available at [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf).
85. See N.Y. Pub. Health L. § 4904(3); see also Empire Justice Center, “Child Health Plus in New York: A Program Primer,” available at <http://www.wnylc.com/health/entry/93>.
86. See 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(3); 80 Fed. Reg. 72192.
87. See 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
88. See 29 C.F.R. § 2560.503-1(h)(3)(i); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192.
89. See 29 C.F.R. § 2560.503-1(i)(2), (j); N.Y. Ins. L. § 4904(c).

90. See 29 C.F.R. § 2560.503-1(i)(2), (j).
91. See 29 C.F.R. § 2560.503-1(i)(2), (j).
92. See 5 C.F.R. § 890.105.
93. See N.Y. Ins. L. § 4904.
94. See *id.*
95. See N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, available at [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf); see also 42 C.F.R. § 438.408.
96. See N.Y. Pub. Health L. § 4904(3); see also Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at <http://www.wnyc.com/health/entry/93>.
97. See 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1); 45 C.F.R. § 147.136(b)(3); N.Y. Ins. L. § 4904(b), 4903(c).
98. See 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192; N.Y. Ins. L. § 4904(b), 4903(c).
99. See 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1); 45 C.F.R. § 147.136(b)(2); 80 Fed. Reg. 72192; N.Y. Ins. L. § 4904(b), 4903(c).
100. See N.Y. Ins. L. §§ 4904(b), 4903(c); 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), 2590.715-2719(b)(2)(ii)(B).
101. See 29 C.F.R. §§ 2560.503-1(h)(3)(vi), (i)(2)(i), 2590.715-2719(b)(2)(ii)(B).
102. See 29 C.F.R. § 2560.503-1(h)(3)(vi), (i)(2)(i), (m)(1).
103. See N.Y. Ins. L. §§ 4904(b), 4903(c).
104. See *id.*
105. See 42 C.F.R. §§ 438.400(b)(3), 438.410; N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, available at [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf).
106. See N.Y. Pub. Health L. § 4904(2), 4903(3); 42 C.F.R. § 457.1160(b); See also Empire Justice Center, "Child Health Plus in New York: A Program Primer," available at <http://www.wnyc.com/health/entry/93>.
107. See N.Y. Ins. L. §§ 4903(b)-(c); N.Y. Pub. Health L. §§ 4903(2)-(3); NY Dep't of Fin. Servs., Insurance Circular Letter No. 6 (2015) (Mar. 30, 2015), [http://www.dfs.ny.gov/insurance/circltr/2015/cl2015\\_06.htm](http://www.dfs.ny.gov/insurance/circltr/2015/cl2015_06.htm).
108. See 29 C.F.R. §§ 2560.503-1(i)(2), (j), 2590.715-2719(b)(2)(E); 45 C.F.R. § 147.136(b)(2)(E); N.Y. Ins. L. § 4904(c); N.Y. Pub. Health L. § 4904(3); Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43333-43334; 76 C.F.R. § 37208-01, 37210; 42 C.F.R. § 438.408; N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf); 5 C.F.R. § 890.105.
109. See 29 C.F.R. §§ 2560.503-1(j), 2590.715-2719(b)(2)(E); 45 C.F.R. § 147.136(b)(2)(E).
110. See 42 C.F.R. § 438.408; N.Y. Dep't of Health, "Medicaid Managed Care Family Health Plus HIV Special Needs Plan Model Contract" (Mar. 1, 2014), Appendix F, [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf).
111. See, e.g., 29 C.F.R. § 2590.715-2719(b)(2)(E).
112. See N.Y. Ins. L. §§ 4914(b); N.Y. Pub. Health L. § 4914(b); 29 C.F.R. §§ 2560.503-1(j), 2590.715-2719(b)(2)(E); 45 C.F.R. § 147.136(b)(2)(E); 42 C.F.R. § 438.408(d).
113. See N.Y. Ins. L. § 4904(b); N.Y. Pub. Health L. § 4914(2).
114. See N.Y. Ins. L. §§ 4904(b), 4910(b)(1)(B); N.Y. Pub. Health L. §§ 4904(2), 4910(2)(a)(ii); [Healthcare.gov](https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals), "Internal Appeals," <https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals>.
115. Although self-insured large group plans that are grandfathered are not legally required to provide an external appeal/review process, these plans may provide one anyway. You should check with your plan to find out whether you can file an [external appeal/review](#).
116. See N.Y. Ins. L. §§ 4910, 4914; N.Y. Pub. Health L. §§ 4910, 4914; N.Y. Dep't of Fin. Servs., New York State External Appeal, <http://www>.

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

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



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

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

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



# 12 Resources

## ADDITIONAL RESOURCES

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

## HELPFUL WEBSITES

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

# 13

# Sample Appeals, Complaints, & Letters<sup>1</sup>

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

For every appeal, complaint or letter:

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

Please read the additional tips prior to each sample.

## 1. Internal Appeal Letter

- [a. Sample Patient Internal Appeal \(Parity\)](#)
- [b. Sample Provider Letter In Support of Patient Internal Appeal \(Parity\)](#)
- [c. Sample Provider Internal Appeal \(Parity\)](#)

## 2. External Appeal Letter

- [a. Sample Patient External Appeal \(Parity\)](#)
- [b. Sample Provider External Appeal \(Parity\)](#)

## 3. Request Letter for Information/Documents

- [a. Sample Patient Request for Documents \(Parity\)](#)
- [b. Sample Provider Request for Documents \(Parity\)](#)

## 4. Complaint Letter to State Government Agencies

- [a. Sample Patient Complaint to State Government Agency \(Parity\)](#)
- [b. Sample Provider Complaint to State Government Agency \(Parity\)](#)

## 5. Complaint Letter to Federal Government Agencies

- [a. Sample Patient Complaint to Federal Government Agency \(Parity\)](#)
- [b. Sample Provider Complaint to Federal Government Agency \(Parity\)](#)

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



## a. Sample Patient Internal Appeal (Parity)



### Tip For Patients Filing Internal Appeals

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

## Sample Patient Internal Appeal (Parity)

[Date]

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

[Your Name]

[Your Address]

[Your Insurance Plan's Address for Appeals]

**Re:** [Patient's Name]

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

**Date of Birth:** [Patient's Date of Birth]

**Claim Number:** [Claim # from Patient's Explanation of Benefits or Denial Letter]

**[If Patient Has Already Received the Service] Date of Service:** [The Date Patient Received the Services That Were Denied (Check Your Bill or Denial Letter If You Are Not Sure)]

**Provider:** [Name of Doctor and/or Hospital]

### To Whom It May Concern:

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

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

*Plan] appears to be violating those laws as well.]*

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

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

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

Sincerely,

[Your Name]

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

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



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[Patient Internal Appeal](#)





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



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

- » Provide detail, including: patient’s medical history; patient’s condition and recommended treatment; if relevant, unsuccessful attempts at treating the condition; why alternative treatments are inferior.
- » Explain why the treatment is medically necessary. If time permits, request that the health plan provide you with the medical criteria it is using (you are legally entitled to this information—see [Section 4–B](#) for more information). If you are unable to get a copy of the plan’s medical necessity criteria, you can explain that the treatment is medically necessary because it will: prevent illness or disability; ameliorate the effects of an illness; allow patient to maintain maximum functional capacity; and/or standard treatments have failed.
- » Note if the plan is applying its medical necessity criteria incorrectly. For example, the denial letter says treatment is not medically necessary because the patient is not exhibiting withdrawal symptoms, but the plan’s medical necessity criteria for the treatment requested do not require patient to be exhibiting withdrawal symptoms.

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

[Print on Your Letterhead]

[Date]

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

**Re:** [Patient's Name]

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

[If Patient Has Already Received the Service] **Date of Service:** [The Date Patient Received the Services That Were Denied]

### To Whom It May Concern:

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

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

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

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

Sincerely,

[Your Name]

[Title]

[If You Are Attaching Documentation: Enclosure]



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[Provider Letter Support Patient Internal Appeal](#)





### c. Sample Provider Internal Appeal (Parity)



#### Tips For Providers Filing Internal Appeals (Parity)

- » Provide detail, including: patient's medical history; patient's condition and recommended treatment; if relevant, unsuccessful attempts at treating the condition; why alternative treatments are inferior.
- » Explain why the treatment is medically necessary. If time permits, request that the health plan provide you with the medical criteria it is using (you are legally entitled to this information—see [Section 4–B](#) for more information). If you are unable to get a copy of the plan's medical necessity criteria, you can explain that the treatment is medically necessary because it will prevent illness or disability, ameliorate the effects of an illness, allow patient to maintain maximum functional capacity, and/or standard treatments have failed.
- » Note if the plan is applying its medical necessity criteria incorrectly. One such example would be if the denial letter says treatment is not medically necessary because the patient is not exhibiting withdrawal symptoms, but the plan's medical necessity criteria for the treatment requested do not require patient to be exhibiting withdrawal symptoms.



## Sample Provider Internal Appeal (Parity)

[Print on Your Letterhead]

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

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

**Re:** [Patient's Name]

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

**Date of Birth:** [Patient's Date of Birth]

**Claim Number:** [Claim # from Patient's Explanation of Benefits or Denial Letter]

[If Patient Has Already Received the Service] **Date of Service:** [The Date Patient Received the Services That Were Denied]

**Provider:** [Name of Doctor and/or Hospital]

### To Whom It May Concern:

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

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

Furthermore, your denial of coverage or payment for the above-referenced services appears to violate the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("federal parity law").<sup>2</sup> The federal

parity law requires health insurance plans that provide substance use disorder and mental health benefits to provide them at parity with other medical and surgical benefits. [If patient's plan is protected by New York State law (see [Section 6](#)): New York State also has laws requiring health plans to cover substance use disorder and mental health benefits at parity with other medical and surgical benefits, and [Name of Patient's Health Insurance Plan] appears to be violating those laws as well.]

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

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

Sincerely,

[Your Name]

[Title]

[If You Are Attaching Documentation: Enclosure]

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



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[Provider Internal Appeal](#)





### a. Tips For Patients Filing External Appeals (Parity)



#### Tips For Patients Filing External Appeals (Parity)

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

## Sample Patient External Appeal (Parity)

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

[Date]

[Your Name]

[Your Address]

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

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

Patient's Name: [Patient's Name]

Patient's Health Plan: [Patient's Health Plan]

Patient's Provider: [Name and Phone # of Doctor and/or Hospital]

To Whom It May Concern:

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

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

[If Patient's Plan Has an Annual or Lifetime Limit for SUD/MH Benefits: The Affordable Care Act forbids health plans from placing annual or lifetime limits

on anything considered an "essential health benefit." In New York, inpatient and outpatient mental health and substance use disorder treatment are considered "essential health benefits." Therefore, [Name of Patient's Health Insurance Plan] is violating the Affordable Care Act by placing annual or lifetime limits on [Insert Treatment Type].]

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

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

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

Sincerely,

[Your Name]

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

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



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[Patient External Appeal](#)





## b. Sample Provider External Appeal (Parity)

### External Appeal Letter



#### Tips For Providers Filing External Appeals (Parity)

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

## Sample Provider External Appeal (Parity)

[Print on Your Letterhead]

[If Urgent Appeal, write URGENT/EXPEDITED APPEAL]

[Date]

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

### Re: Attachment to External Appeal Application

**Patient's Name:** [Patient's Name]

**Patient's Health Plan:** [Patient's Health Plan]

### To Whom It May Concern:

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

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

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

other medical and surgical benefits, and [Name of Patient's Health Insurance Plan] appears to be violating those laws as well.]

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

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

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

Sincerely,

[Your Name]

[Title]

[If You Are Attaching Documentation: Enclosure]

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



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[Provider External Appeal](#)





## a. Sample Patient Request for Documents (Parity)



### Tips For Patients Requesting Documents (Parity)

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

## Sample Patient Request For Documents (Parity)

[Date]

[Your Name]

[Your Address]

[Your Insurance Plan's Address]

**Re: Patient's Name:** [Patient's Name]

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

To Whom It May Concern:

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

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

drugs are covered by my health plan. [Optional: In particular, please explain whether, and under what circumstances, [Insert Name of Medication You Want to Access] is covered by my health plan.]]

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

Sincerely,

[Your Name]

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



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[Patient Information Request for Documents](#)







## b. Sample Provider Request for Documents (Parity)



### Tips For Providers Requesting Documents (Parity)

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

## Sample Provider Request For Documents (Parity)

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

[Patient's Insurance Plan's Address]

**Re: Patient's Name:** [Patient's Name]

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

**Date of Birth:** [Patient's Date of Birth]

**Provider:** [Name of Doctor and/or Hospital]

**To Whom It May Concern:**

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

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

Whether, and under what circumstances, existing and new prescription drugs are covered by {Patient Name}'s health plan. {Optional: In particular, please explain whether, and under what circumstances, [Insert Name of Medication You Want to Access] is covered by [Patient Name]'s health plan.}}

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

Sincerely,

[Your Name]

[Your Title]

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



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[Provider Information Request for Documents](#)





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



### Tips For Patients Complaining To State Government Agencies (Parity)

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

## Sample Patient Complaint To State Government Agency (Parity)

[Date]

[Your Name]

[Your Address]

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

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

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

**To Whom It May Concern:**

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

The federal parity law requires health plans that offer mental health (MH) and substance use disorder (SUD) benefits to offer them at parity with other medical and surgical benefits. Specifically, the law: (1) forbids plans from having any separate financial requirements or treatment limitations that apply only to MH/SUD benefits; (2) forbids plans from applying

financial requirements or treatment limitations to MH/SUD benefits that are more restrictive than the predominant ones that are applied to substantially all medical/surgical benefits; (3) requires plans to provide out-of-network benefits for MH/SUD services if it offers them for medical/surgical services; and (4) requires plans to disclose medical necessity criteria and other information upon request.' The Affordable Care Act (ACA) incorporates the federal parity law and includes additional protections for people seeking MH/SUD care.

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

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

## Complaint Letter to State Government Agencies

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

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

Thank you for your assistance.

Sincerely,

*[Name]*

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

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



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[Patient Complaint to State Government Agency](#)





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



### Tips For Providers Complaining To State Government Agencies (Parity)

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

## Sample Provider Complaint To State Government Agency (Parity)

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

[Date]

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

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

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

**To Whom It May Concern:**

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

The federal parity law requires health plans that offer mental health (MH) and substance use disorder (SUD) benefits to offer them at parity with other medical and surgical benefits. Specifically, the law: (1) forbids plans from having any separate financial requirements or treatment limitations that apply only to MH/SUD benefits; (2) forbids plans from applying financial requirements or treatment limitations to MH/SUD benefits that are more restrictive than the predominant ones that are applied to substantially all medical/surgical benefits; (3) requires plans to provide out-of-network benefits for MH/SUD services if it offers them for medical/surgical services;

and (4) requires plans to disclose medical necessity criteria and other information upon request.<sup>1</sup> The Affordable Care Act (ACA) incorporates the federal parity law and includes additional protections for people seeking MH/SUD care.

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

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



## Complaint Letter to State Government Agencies

treatment at a time).]

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

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

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

Thank you for your assistance.

Sincerely,

[Name]

[Title]

[If You Are Including Supporting Documentation: Enclosure]

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



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[Provider Complaint to State Government Agency](#)





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



### Tips For Patients Complaining To Federal Government Agencies (Parity)

- » Send copies of supporting documents along with your complaint, including (where applicable): a copy of your insurance card; copies of complaints made to State government agencies (DFS and/or DOH) and any responses you received to your complaints; copies of denials/adverse benefit determinations by the plan; copies of the plan's and external review agent's determinations in any internal and external appeals; any materials that were submitted with your appeals and complaints to State agencies; supporting information from your health care provider; plan documents showing that the plan limits or excludes MH/SUD care; copies of the plan's medical necessity criteria; copies of any requests you made for information you are entitled to (like medical necessity criteria) and any responses received from the plan.
- » Make a copy of your complaint and any attachments, and keep them in a safe place.
- » **If you are complaining to the U.S. Department of Labor (DOL),** you may submit an [online complaint form](#) (also available [online as a printable mail-in form](#)) and either paste your complaint based on this sample into the section titled "Other Information and Comments," or include your complaint based on this sample as an attachment. If you have questions, you may contact [your regional office](#) of DOL's Employee Benefits Security Administration. If you live in eastern New York, you may call (212) 607-8600 with questions. If you live in central or western New York, you may call (617) 565-9600 with questions. You may also call DOL at (866) 444-3272.
- » **If you are complaining to the U.S. Department of Health & Human Services (HHS),** you can email your complaint based on this sample and any supporting documentation to [phig@cms.hhs.gov](mailto:phig@cms.hhs.gov). If you have any questions, you can call HHS at (877) 267-2323.
- » Legal Action Center is gathering information about possible parity violations in New York. If you are willing, please send us a copy of your complaint. We will keep your information confidential, and will only use the complaint for informational purposes. We will not be evaluating your complaint for possible representation. Please send the copy of your complaint either by email (send to [lacinfo@lac.org](mailto:lacinfo@lac.org) with subject line "Parity Complaint"), fax (send to 212-675-0286; write ATTN: Parity Complaint), or mail (send to Parity Complaint, Legal Action Center, 225 Varick St. Suite 402, New York, NY 10014).

## Sample Patient Complaint To Federal Government Agency (Parity)

[Date]

[Your Name]

[Your Address]

[CHOOSE APPROPRIATE FEDERAL GOVERNMENT AGENCY:]

[If You Live In Eastern NY:]

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

[If You Live In Central or Western NY:]

[U.S. Department of Labor – Employee Benefits Security Administration  
Boston Regional Office  
JFK Federal Bldg  
15 New Sudbury St, Room 575  
Boston, MA 02203  
Fax (617) 565-9666]

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

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

**To Whom It May Concern:**

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

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

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

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

## Complaint Letter to Federal Government Agencies

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

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

Thank you for your assistance.

Sincerely,

*[Name]*

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

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



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



### Tips For Providers Complaining To Federal Government Agencies (Parity)

- » Send copies of supporting documents along with your complaint, including (where applicable): copies of complaints made to State government agencies (DFS and/or DOH) and any responses you received to your complaints; copies of denials/adverse benefit determinations by the plan; copies of the plan's and external review agent's determinations in any internal and external appeals; any materials that were submitted with appeals and complaints to State agencies; clinical explanation of why the patient(s) needs the care at issue; plan documents showing that the plan limits or excludes MH/SUD care; copies of the plan's medical necessity criteria; copies of any requests you or your patient(s) made for information you are entitled to (like medical necessity criteria) and any responses received from the plan.
- » Make a copy of your complaint and any attachments, and keep them in a safe place.
- » **If you are complaining to the U.S. Department of Labor (DOL)**, you may submit an [online complaint form](#) (also available [online as a printable mail-in form](#)) and either paste your complaint based on this sample into the section titled "Other Information and Comments," or include your complaint based on this sample as an attachment. If you have questions, you may contact [your regional office](#) of DOL's Employee Benefits Security Administration. If you live in eastern New York, you may call (212) 607-8600 with questions. If you live in central or western New York, you may call (617) 565-9600 with questions. You may also call DOL at (866) 444-3272.
- » **If you are complaining to the U.S. Department of Health & Human Services (HHS)**, you can email your complaint based on this sample and any supporting documentation to [phig@cms.hhs.gov](mailto:phig@cms.hhs.gov). If you have any questions, you can call HHS at (877) 267-2323.
- » Legal Action Center is gathering information about possible parity violations in New York. If you are willing, please send us a copy of your complaint. We will keep your information confidential, and will only use the complaint for informational purposes. We will not be evaluating your complaint for possible representation. Please send the copy of your complaint either by email (send to [lacinfo@lac.org](mailto:lacinfo@lac.org) with subject line "Parity Complaint"), fax (send to 212-675-0286; write ATTN: Parity Complaint), or mail (send to Parity Complaint, Legal Action Center, 225 Varick St. Suite 402, New York, NY 10014).

## Sample Provider Complaint To Federal Government Agency (Parity)

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

[Date]

[CHOOSE APPROPRIATE FEDERAL GOVERNMENT AGENCY:]

[If You Live In Eastern NY:]

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

[If You Live In Central or Western NY:]

[U.S. Department of Labor – Employee Benefits Security Administration  
Boston Regional Office  
JFK Federal Bldg  
15 New Sudbury St, Room 575  
Boston, MA 02203  
Fax (617) 565-9666]

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

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

**To Whom It May Concern:**

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

The federal parity law requires health plans that offer mental health (MH)

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

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

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



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

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

Thank you for your assistance.

Sincerely,

*[Name]*

*[Title]*

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

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



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