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The Health Insurance Appeals Guide

A Consumer Guide for Filing Mental Health and Substance Use Disorder (MH/SUD) Appeals

Acknowledgements

Authors: Garry Carneal, JD; Mary Covington and Justin Eckman.

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Foreword

Treating diseases of the brain is as important as treating any physical ailment or condition. Yet, the health insurance system in the United States has never covered mental health and substance use disorders (MH/SUDs) appropriately. As a result, depression, anxiety, addiction, and other mental health conditions often go unaddressed, leading to poor clinical outcomes and increased spending on the medical/surgical side of health care. Historically high rates of suicides and overdoses in this country are evidence of our failure to properly acknowledge, prioritize and treat MH/SUDs.

This Guide details important information that consumers, providers and other stakeholders need to know when filing appeals for denials of MH/SUD treatment and related services. The publication was written by leading health insurance experts to help educate individuals about their appeal rights and explain the steps in the appeals process.

To promote health equity, government protections have been implemented to promote "due process" protections for consumers who are denied care because an insurer will not authorize "medically necessary" coverage or otherwise fails to reimburse for care that is required under the applicable insurance policy or by law. Unfortunately, consumers often are not provided a meaningful opportunity to have their denied claims reconsidered because consumers are not aware of their appeal rights or the most appropriate pathway to file an appeal. Even when patients and providers understand their appeal rights, insurers often uphold their "adverse benefit determinations" based on questionable grounds.

Despite these obstacles, The Kennedy Forum is committed to fighting for consumers' right to receive MH/SUD care. Understanding the appeal rights outlined in this Guide is a great start for consumers to be equipped to get the coverage they need and are legally obligated to receive.

We also encourage individuals to register complaints against their insurers at **www.ParityRegistry.org**, which also includes many helpful resources regarding appeals. Please join us in breaking the silence and bringing transparency to a system that oppresses those with MH/SUDs. Visit **www.DontDenyMe.org** to learn more.

Patrick J. Kennedy
Former U.S. Representative (D-RI)
Founder, The Kennedy Forum

Foreword

You can't have health without mental health, and yet, health insurance companies often make it hard—if not impossible—to get mental health treatment. Many people don't realize they can actually challenge their insurance plan when they are denied care or forced out-of-network. We won't say it's easy, but it is your right. This Guide is intended to help you know your rights and navigate the appeals process to get the affordable care you and your family deserve.

Health plans often deny people with mental health conditions appropriate care or force them to go out-of-network and pay high out-of-pocket costs, leaving many to go without care altogether. Adults in commercial PPO health plans are over five times more likely to be forced into using costly, out-of-network providers for mental health treatment compared with other medical care. And for parents of children who need mental health care, it's even more challenging. Parents are 10 times more likely to have to go out-of-network when seeking care for their child. Even worse, many people are flat-out denied coverage for necessary mental health care by their health insurance plan. If people had to resort to out-of-network care or were denied coverage for cancer or diabetes, there would be outrage.

NAMI, as the nation's largest grassroots mental health organization, is proud to partner with The Kennedy Forum and our many allies to strengthen parity oversight and enforcement in this country. We're looking forward to the day that health plans work as hard to provide mental health care as they currently do to deny it. If we have anything to do with it, one day no one will need this Guide. But in the meantime, we are grateful to The Kennedy Forum for this invaluable tool. We hope you'll use it and feel empowered to challenge the unjust barriers often erected by health insurance plans.

Daniel H. Gillison, Jr.
CEO, The National Alliance on Mental Illness

Introduction

Welcome to *The Health Insurance Appeals Guide*. We hope the information contained in this document will empower individuals to better understand their rights to file a health insurance appeal. Whether the individual is a patient, provider, family member, caregiver, or advocate, our shared health care goal is to get the right care to the right patient at the right time. Unfortunately, this is easier said than done. The health insurance system in the United States is complex and confusing. Individuals are often denied coverage by their insurance companies for needed treatment, even though, in most cases, insurers have a contractual and regulatory responsibility to cover and reimburse their members for evidence-based care that improves a patient's clinical outcome.

Through a system of managed care, health plans can make "medical necessity" or other types of coverage decisions that lead to denials. Sometimes these decisions are made for the right reasons—and prevent patients from receiving dangerous or unnecessary care—but, far too often, these decisions are made with subjective reasoning. In these cases, patients are left without access to care or are stuck with medical bills they often cannot afford.

Recognizing the importance of health care decisions in the lives of their constituents, federal and state regulators created a health insurance appeals system to provide an opportunity for people to challenge denials. The process of questioning an insurance company's decision, or lack thereof, related to an insured's health care needs has come to be known as the "insurance appeals process." It is this process we seek to explain.

Part I of the Guide includes a list of key acronyms and defines commonly used insurance and appeals terminology.

Part II offers important background information about health insurance and helps individuals determine what type of health plan they have. This information is necessary to understand before filing an insurance appeal because the plan type will determine what appeal options a patient has, as well as the regulatory bodies charged with overseeing the health insurer and maintaining the integrity of the appeals process.

Part III contains information about the administrative and clinical appeals process. We explain the different levels of appeals, as well as the ways in which insurance denials and appeals are broadly categorized and handled. Understanding the different types of denials and appeals procedures can help individuals better understand how the process works and draft a more effective appeal.

Part IV explores the landmark Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), also known as the Federal Parity Law, and explains its significance in regards to appeals. The history of the Federal Parity Law and related efforts are discussed, as well as the many ways in which insurance companies have historically failed to fully comply with the law. This section also explains how to assert and prove a parity violation, while leveraging the MHPAEA in appeal letters.

Part V focuses on best practices for drafting an appeal letter and provides appeal advice for the denial classifications identified in Part III of the booklet.

Part VI offers some final thoughts on the health insurance appeals process.

Parts VII and **VIII** of the booklet provide important resources for appeal writers, including lists of frequently asked questions (FAQs) and additional resources.

Although this Guide focuses primarily on MH/SUD appeals, the general information about the appeals process—and recommendations for successful appeals—also apply to medical/surgical coverage.

Part I

Terminology

A. Key Acronyms

The following abbreviations are used in this Guide, and are defined in the glossary or within the text:

ACA—The Patient Protection and Affordable Care Act (see also PPACA)

AHP—Association Health Plan

CMS—U.S. Centers for Medicare and Medicaid Services

COC—Certificate of Coverage

DOL—U.S. Department of Labor

EAP—Employee Assistance Program

EHBs—Essential Health Benefits

EOB—Explanation of Benefits

EOC—Evidence of Coverage

EPO—Exclusive Provider Organization

ERISA—Employee Retirement Income Security Act of 1974

FDA—U.S. Food and Drug Administration

FEHB Program—Federal Employees Health Benefits Program

FFS—Fee-for-Service

FR—Financial Requirement

HDHP—High Deductible Health Plans

HHS—U.S. Department of Health and Human Services

HIPAA—Health Insurance Portability and Accountability Act

HMO—Health Maintenance Organization

HSA—Health Savings Account

IOP—Intensive Outpatient Program

IRO—Independent Review Organization

MBHO—Managed Behavioral Health Organization

MEWA—Multiple Employer Welfare Arrangement Plans

MH/SUD—Mental Health and Substance Use Disorders

MHPAEA—The Mental Health Parity and Addiction Equity Act of 2008, also known as the Federal Parity Law

NQTL—Non-Quantitative Treatment Limitation

PCP—Primary Care Provider

PHP—Partial Hospitalization Program

PPACA—The Patient Protection and Affordable Care Act (see also ACA)

POS—Point of Service

PPO—Preferred Provider Organization

QTL—Quantitative Treatment Limitation

SBC—Summary Benefits and Coverage

SPD—Summary Plan Description

TPA—Third Party Administrator

UCR—Usual, Customary and Reasonable

UM—Utilization Management

B. Glossary

Like many other industries, health insurance has its own jargon and terminology. This glossary will help readers to better understand their insurance coverage and the appeal processes outlined in the pages that follow. We recommend keeping these definitions handy when filing a health insurance appeal or researching/asserting a parity violation.

HELPFUL TIP

The ACA also established a standard glossary of terms, which includes terminology not found in the glossary for this Guide.

The ACA glossary can be accessed at **www.healthcare.gov/glossary**.

ACA: The Patient Protection and Affordable Care Act— sometimes known as ACA, PPACA, or "Obamacare"—is a comprehensive health care reform law enacted in March 2010. The Act established minimum health care standards that must be obeyed by all non-grandfathered health insurance plans, including the right to an external review for decisions involving medical judgment.

Administrative Appeal: An appeal concerning the administrative processes of a health insurer. Administrative appeals do not involve clinical judgment and are only eligible for external review in certain states. Individuals should check their state department of insurance's website or contact their regulator directly for more information.

Adverse Benefit Determination: Any action by a health plan that denies or limits payment for the requested behavioral or medical treatment. The health plan must inform the patient of the adverse benefit determination and generally does so through an Explanation of Benefits or denial letter. Synonymous with a denial of care.

Appeal: The legal right of an insured individual, provider, or an authorized representative to contest a health plan or third-party determination to deny or limit payment for requested behavioral health or medical treatment.

Appealing a Claim: The process of contesting a denied behavioral health or medical claim in order to secure payment for services. Individuals, providers, or authorized representatives may submit appeals verbally or in writing. Most health insurers have their own processes and timelines, which may be subject to state and federal regulations.

Appellant: The individual, authorized representative, or provider that is appealing a denial of care or other legal issue.

Association Health Plan: A health insurance arrangement formed by associations and employer groups for the benefit of association members or employees. For example, association health plans (AHPs) allow small groups to band together to purchase the types of coverage that are available to large employers, which can be less expensive and better tailored to the needs of their members or employees. AHPs are regulated by the federal and state government. When filing an appeal, consumers need to find out how the AHP is offered and who is the primary regulator to ensure the right process is followed as highlighted in this Guide.

Authorized Representative: The person an individual chooses to act on their behalf in insurance or legal matters, such as a family member or spouse. Authorized Representatives must be identified in writing, and some authorizations require notarization.

Balance Billing: The amount an individual could be responsible for (in addition to any copayments, deductibles, or coinsurance) when using an out-of-network provider. Balance billing represents the fee for a particular service that exceeds what the insurance plan recognizes as the allowable out-of-network charge for that service. The additional payment is considered the member's responsibility. In some cases, balance billing is not permitted by law or by the insurance policy.

Behavioral Health: A descriptive phrase that covers the full range of mental health and substance use disorder (MH/SUD) conditions.

Benefit Classification: One of the six categories of benefits identified by MHPAEA (i.e. in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency, and prescription drugs).

NOTE: For Medicaid coverage, four categories of benefits apply (i.e. inpatient, outpatient, emergency, and prescription drugs).

Carve-Out: An independent behavioral health organization that manages MH/SUD benefits separately from a plan's medical/surgical benefits.

Claim: A bill (or invoice), typically in a standardized form, containing a description of the care provided, applicable billing codes, and a request for payment submitted by the member or provider to the patient's insurance company (or applicable carve-out).

Clinical Appeal: An appeal that involves a "clinical judgment." Examples of clinical appeals are appeals related to a health insurer's denial concerning the medical necessity of care, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, whether or not a service is custodial in nature, or whether or not a service is experimental/investigational.

Clinical Criteria: A utilization management tool established by health insurers to guide them in determining if care is medically necessary or otherwise covered for an insured individual. Clinical criteria describe the required symptoms for admission, continued care, and discharge from various levels of mental health and medical care according to the individual health insurers. Synonymous with medical necessity guidelines, coverage guidelines, and medical necessity criteria.

Coinsurance: The cost-share percentage an insured individual assumes for a clinical service or supply after their deductible has been met. Coinsurance amounts vary based on network use, complexity of service, and other factors explained in an insured individual's Summary of Benefits and Coverage.

Concurrent Review: Utilization management conducted during a patient's hospital stay or course of treatment including outpatient procedures and services. Sometimes called "continued stay review."

Copayment: A set dollar amount that an insured individual is expected to pay at the time of service.

Coverage Appeal: Appeals that focus on the contractual or legal interpretation of the insurance policy itself. Coverage appeals do not involve clinical judgment and are only eligible for external review in certain states. Individuals should visit their state department of insurance's website for more information. Coverage appeals may be called "grievances" in some cases.

Deductible: A dollar amount an insured individual must pay before the insurer will begin to make benefit payments.

Denial of Care: A health insurer's refusal to provide benefits or reimbursement for a behavioral health or medical service. Synonymous with an adverse benefit determination.

Denied Claim: Non-payment of a claim for reimbursement of behavioral health or medical services delivered to the insured individual. The insurance company must inform the patient of the non-payment of the claim and explain why the services are not being reimbursed. Synonymous with a denial of care or an adverse benefit determination.

Denial Letter: A formal letter issued by a health plan that details the reasons why an adverse benefit determination (denial) was issued. Denial letters must include a detailed explanation of the health plan's adverse benefit determination as well as a notification of a patient's right to appeal a denied claim.

Effective Date: The date insurance coverage actually begins. An individual is not considered an insured member until the policy's effective date.

Employee Assistance Programs (EAPs): MH/SUD or medical/surgical treatment services that are sometimes offered by health insurers or employers. Typically, individuals do not have to directly pay for services provided through an EAP. They are deemed to be part of an employer's single group plan for purposes of parity law application.

Employee Retirement Income Security Act (ERISA): A broad-reaching federal law that establishes the rights of health plan participants, requirements for the disclosure of health plan provisions, and funding and standards for the investment of pension plan assets. ERISA provides specific protections for individuals appealing claim denials and establishes requirements for how a plan must review and respond to a claimant's appeal.

> *NOTE: ERISA is not applicable to all health insurance plans—most self-funded and fully-insured health plans offered through an employer are governed by ERISA. Religious organizations and government employee plans are exempt from ERISA.*

Exclusions: Specific conditions, services, treatments, or treatment settings for which a health insurance plan will not provide coverage.

Expedited Appeal: An appeal that is conducted in a short time frame because the denial of care could put the life or health of the patient in serious danger. Expedited appeals are generally responded to in less than 72 hours and must be accompanied by a statement from a medical professional about why the patient's life is in danger without the care and why the appeal review should be expedited.

Explanation of Benefits (EOB): A statement sent from the health plan to an insured member listing services that were billed by a health care provider, how those charges were processed, the allowed amount for each service, the total amount paid, and the total amount of patient responsibility for the claim.

External (Independent) Review: A review of a health insurer's adverse benefit determination by an independent third party that may or may not be contracted with the health insurer. External review is part of the clinical appeals process and is designed to offer an independent and objective review regarding a disputed claim. External review is generally only available for decisions involving clinical judgment, but some states allow external review of all denial types. Individuals should check their state department of insurance website or contact their regulator directly for additional information. External review typically occurs after all internal appeals have been exhausted. However, this outside review can occur simultaneously to the internal appeals process in cases where an appeal decision will affect the life of a patient. Depending on the state, external reviews may be called Independent Medical Reviews (IMRs).

Fail First: Refers to a medical management protocol used by some health plans that requires a patient to demonstrate that they failed at a lower-cost therapy or treatment before the plan will authorize payment for a higher-cost intervention. Fail-first is considered a non-quantitative treatment limitation (NQTL) and must be comparable to and not applied more stringently to behavioral health benefits than medical/surgical benefits.

> *NOTE: Fail-first protocols used to deny coverage for entire behavioral health benefit classifications have been found to violate the Federal Parity Law, as they are not typically utilized for medical conditions, except in the prescription drug class of benefits.*

Formulary: A list of prescription drugs covered by a prescription drug plan or an insurance plan offering prescription drug benefits. Also called a drug list.

Fully-Insured Plan: An insurance plan where the financial responsibility for medical expenses of plan participants is assumed directly by a health insurer. Individual plans offered on the health care marketplace are fully-insured and some employer plans can be fully-insured, depending on the employer contract with the health insurer. Fully-insured plans are regulated by state insurance commissions. Fully-insured plans are also sometimes called fully-funded plans.

Grandfathered Plans: Health plans and other designated insurance arrangements that were in existence prior to March 23, 2010 and have continued as they were originally written. Grandfathered health plans are not required to comply with some of the requirements of the ACA, including the requirement for an external review.

Grievance or Grievance Procedure: A complaint filed by an insured person related to a payment issue or the contractual language of the benefit plan. Sometimes synonymous with a coverage appeal, depending on the language of the health plan and the applicable regulations.

Health Insurance Portability and Accountability Act (HIPAA): A federal law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans and health care providers. HIPAA represents a uniform, federal floor of privacy protections for consumers across the country and outlines the requirements that employer-sponsored group insurance plans, insurance companies, and managed care organizations must satisfy in order to provide health insurance coverage in the individual and group health care markets.

Health Insurer: A licensed organization that provides health insurance coverage to groups or individuals. Synonymous with health plan.

Health Plan: Synonymous with health insurer.

Independent Review Organization: A third-party organization that conducts external reviews. See external review definition.

Individual: The term used throughout this guide to describe the health plan member or subscriber, the patient, the consumer, and other related terms. Typically, this is the person who experiences a denial of care from their health insurer. An individual can also be called an appellant or patient when they are appealing a denial of care or filing a grievance with their health plan.

Inpatient: One of the benefit classifications outlined in MHPAEA. Inpatient is a term used to describe the highest level of care available, often rendered in a hospital setting.

Intensive Outpatient Programs (IOP): This refers to outpatient services performed as an alternative to or step-down from inpatient mental health or substance use disorder treatment. Unlike residential treatment programs, participants are not required to spend the night. Services are generally offered three days per week, three hours per day, and while individual counseling sessions may be offered, there tends to be a focus on group therapy.

Intermediate: A level of care description meaning services that are less intensive than inpatient hospitalization services but more intensive than standard outpatient services. Common MH/SUD examples are residential treatment, outdoor behavioral health programs, partial hospitalization, and intensive outpatient care. Common medical/surgical examples are skilled nursing facilities and rehabilitation hospitals.

Internal Appeal: An appeal review conducted by the health insurer. The first appeal in the appeals process is always an internal appeal, and some plans include two or more levels of internal appeal.

Managed Behavioral Health Organization (MBHO): An organization that provides behavioral health services, including authorization, claims processing, appeal decisions, and other administrative services, through managed care techniques. MBHOs are either a distinct part of a health insurer or a carve-out.

Medicaid: A joint federal and state program that provides comprehensive hospital, medical, and behavioral health coverage to low-income individuals, qualifying seniors, and disabled individuals. The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act, 42 U.S.C. §§ 1396 et seq. Under Medicaid, the federal government provides matching funds to states to enable the local jurisdictions to provide coverage to individuals who meet certain eligibility requirements. The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to cover the costs of necessary medical and behavioral health services.

Medically Necessary: Health care services that are clinically indicated for the diagnosis and/or treatment of a medical or behavioral health condition.

Medical Necessity Appeal: A clinical appeal filed when the health plan has denied payment or reimbursement for a level of care or service based on a "lack of medical necessity."

Medical/Surgical Benefits: For purposes of this Guide, the phrase refers to insurance coverage for medical and surgical (non-behavioral health) services.

Medicare: A federal government program established under Title XVIII of the Social Security Act of 1965 to provide hospital expense and medical expense insurance to elderly and disabled persons. Medicare is divided into four parts. Part A covers hospital, skilled nursing, and hospice services. Part B covers outpatient services. Part C is an alternative called Managed Medicare, which allows patients to choose health plans with at least the same service coverage as Parts A and B and (most often) more than the benefits of Part D. Part D covers mostly self-administered prescription drugs.

Mental Health and Substance Use Disorders (MH/SUDs): The phrase used in the Mental Health Parity and Addiction Equity Act (MHPAEA) and accompanying regulations, as well as certain state laws, to describe a range of behavioral health conditions.

Member: Also referred to as a "plan participant", an individual who is enrolled in a health insurance plan. This can include the primary enrollee and their dependents.

Member Financial Requirements: Any financial obligation for which the member is responsible. Examples of member financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums.

MHPAEA: An acronym for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the landmark legislation that requires insurers to cover treatment for mental health and substance use disorders no more restrictively than treatment for illnesses of the body, such as diabetes and cancer. Synonymous with the Federal Parity Law.

Network: The group of physicians, hospitals, and other health care providers that a health plan has contracted with to deliver medical and/or behavioral health services to its members.

Non-Quantitative Treatment Limitation (NQTL): Any non-numeric treatment limitation (e.g., non-financial limitation or other limitation on treatment that cannot be counted) imposed by a health plan that limits the scope or duration of treatment of MH/SUD or medical/surgical care.

Out-of-Network: Physicians, hospitals, facilities, and other health care providers that are not contracted with the plan or insurer to provide health care services at discounted rates. Depending on an individual's plan, expenses incurred by services provided by out-of-network health care professionals may not be covered or may be only partially covered.

Out-of-Pocket Maximum: The highest dollar amount a member will have to pay for covered services in a given plan year. After a member spends this amount on deductibles, copayments, and coinsurance, the health plan pays 100% of the costs of covered benefits until the beginning of the next plan year.

Outpatient Care: Treatment that is provided to a patient on a non-24-hour basis without an overnight stay in a hospital or other inpatient or residential facility.

Parity: Often used as a short reference to ensuring health equity between MH/SUD insurance coverage and medical/surgical insurance coverage.

Partial Hospitalization Program (PHP) or Partial Hospitalization Services: Also called "partial hospital days," this refers to outpatient services performed as an alternative to or step-down from inpatient mental health or substance use disorder treatment. Unlike residential treatment programs, participants are not required to spend the night. Services are generally offered five days per week, four to six hours per day.

Plan Participant: See definition for "Member."

Preauthorization: A decision by a health insurer or plan (before a patient receives a service) that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. The insured individual's plan may require preauthorization for certain services before they receive them, except in an emergency. Also referred to as prior authorization, prior approval, or precertification, depending on the health insurer.

Prospective Review: Utilization management conducted prior to a patient's admission, stay, or other service or course of treatment, including outpatient procedures and services. Sometimes called "pre-certification review" or "prior authorization review."

Quantitative Treatment Limitation (QTL): Any treatment limitation expressed numerically, such as one based on frequency of treatment, number of visits, days of coverage, or days in a waiting period that limits MH/SUD or medical/surgical care.

Retrospective Review: Review conducted by the insurer after services have been provided to the patient. This activity is typically part of a utilization management program.

Services: Various treatments, therapies, drug coverage, and other benefits offered through a health insurer.

Remark Codes: A letter or number system typically presented and defined at the bottom of an Explanation of Benefits to illustrate how the insurance claim was processed and why the insurance company denied all or part of a claim. May also be referred to as reason codes, denial codes, or processing codes, depending on the insurer.

Self-Funded Plan (ERISA): The type of plan typically used by larger companies or unions where the employer/union collects premiums from members and takes on the responsibility of paying employee and dependent medical claims. Such employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator (TPA), or they can be self-administered. The employer/union may also use a stop loss insurance carrier to handle large insurance claims. The self-insured employee health benefit plans are exempt from many state laws and are instead subject to federal (ERISA) law. Self-funded plans are sometimes called self-insured plans.

Stop Loss Insurance: An insurance product that provides protection against catastrophic or unpredictable losses. This type of insurance arrangement is purchased by employers who have decided to self-fund their employee benefit plans, but do not want to assume full risk for losses arising from the plans. Under a stop-loss policy, the insurance company (and not the employer) becomes liable for losses that exceed certain threshold limits for the covered population and for each individual. The type and level of stop loss insurance associated with a health plan will impact whether the primary regulator is the state or the federal government.

Summary of Benefits and Coverage (SBC): An abbreviated version of a health plan's coverage, typically shown in a grid. This summary gives a snapshot of costs, benefits, and coverage. SBCs can be included as a portion of the Summary Plan Description or may be provided as a separate document.

Summary Plan Description (SPD): A comprehensive description of the benefits provided by a health plan to its members. SPDs also include a description of how the plan operates, as well as a list of what services are and are not covered under the insurance policy. The SPD constitutes the insurance agreement between the insurer and insured and is the governing document of the plan. SPDs should be offered through the insurance company's website, an online exchange, or in-house through an employer's Human Resources department. The insurance broker, plan representative, or Human Resources personnel will know where to find it if the insured individual cannot locate it. Synonymous with benefit booklet, Certificate of Coverage (COC), and insurance policy.

Third-Party Administrator (TPA): An individual or organization that is charged with managing the administrative affairs of a self-funded insurance plan. Depending on the delegated authority of the plan, the TPA may administer the claims, appeals, and/or complaints.

Usual, Customary and Reasonable (UCR) Fees: A pricing methodology used to determine out-of-pocket charges for health care services. UCR Fees are often based on the average fee charged by a particular type of health care practitioner within a geographic area for a particular type of service. Plans use a variety of methods to determine UCR Fees, and insured individuals should check their insurance policy for the specific method used to calculate UCR Fees. Out-of-network providers may charge a fee that is more than the UCR Fee and an insured individual may be responsible for any remaining portion of the bill—in addition to any copayment, coinsurance, and deductible amount.

Utilization Management: Sometimes referred to as "utilization review," a process or program designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings.

Disclaimer: This list of terms is not intended to be exhaustive, and definitions will vary based on types of insurance products and applicable laws. These terms are useful in understanding the Federal Parity Law and navigating the appeals process. However, the definitions or any other information contained in this Guide should not be relied upon as legal advice. Consumers, providers, and other stakeholders should consult directly with a regulator, attorney, or advocate for specific advice.

Part II

What Is Health Insurance?

> Insurance, in its most basic sense, is the allocation of the financial risk of replacing items of great value. Our homes, cars, businesses, and health all hold great monetary value, and in many cases, the cost to replace property or treat illness or injury is too great for individuals to cover without assistance.

In the case of health insurance, individuals enroll in health plans and similar arrangements to help reallocate the risk of expensive medical procedures from themselves to a third party such as an insurance company, employer, association group, or government plan. The insurer, employer, or other health plan sponsor agrees to pay for a certain percentage of medical costs in exchange for a monthly premium from the people they cover. In terms of the spreading of risk, insured populations typically have a greater percentage of individuals who are healthier compared to those who are sick or experience a sudden emergency medical procedure. But of course, circumstances may change for any given individual in any particular year.

We refer to the legal entities that assume the insurance risk generically as either health insurers or health plans throughout this Guide, but they also go by specific names as well. Aetna, Blue Cross and Blue Shield, Cigna, Kaiser, and United Healthcare are examples of companies that offer health insurance or health plans. In addition, plan names are often customized for each region or market segment.

In most situations, the health insurer or the third-party administrator (TPA), who typically work on behalf of a self-funded employer or an association health plan, implement mechanisms to oversee how recommended care, services or treatment are covered and reimbursed. Under the auspices of managed care, a primary goal is to make sure patients are receiving the right level of care at the right time and in the right setting. While the stated goals over managed care may be to optimize quality and clinical outcomes, sometimes monitoring costs and profitability trump these considerations.

Managed care now touches almost every aspect of health care in the United States. The managed care structure of a health plan determines what providers an insured individual can and cannot see, and how much those providers will be reimbursed for their services. Ultimately, the funder and sponsor of a plan have significant influence on how it is managed as well. Because so much is at stake, regulators have the authority to oversee most aspects of managed care to provide a system of checks and balances. In fact, one of those oversight mechanisms is the health insurance appeals process.

A. What Are the Key Insurance Documents?

Heath insurers must provide members with certain documents, which contain key information necessary to participate in their health plan, as well as the specific rules governing the coverage agreement between the health plan and the member.

The three important documents that every consumer should have in order to understand their health plan are: 1) a health insurance identification (ID) card, 2) a Summary of Benefits and Coverage (SBC), and 3) a Summary Plan Description (SPD).

1. ID Card

An individual's ID card is their passport to health care. It contains important information, such as the name of the individual's health insurer, members covered under the policy, the plan type, and network type. Additionally, the ID card contains important contact information for the plan's customer service and preauthorization departments. Insured individuals should keep a copy of their health insurance ID card with them at all times.

2. Summary of Benefits and Coverage (SBC)

An SBC is an abbreviated version of a health plan's coverage, typically shown in a grid. This summary gives a snapshot of an insurance policy's costs, benefits, and coverage. The SBC can be included as a portion of the Summary Plan Description or may be provided as a separate document. This snapshot of an individual's benefits is helpful when they want a quick understanding of what the plan does or does not cover.

3. Summary Plan Description (SPD)

The SPD is a more comprehensive description of the benefits provided by a health plan to its members. SPDs also include a description of how the plan operates, as well as a list of what services are and are not covered under the insurance policy.

The SPD constitutes the insurance agreement between the insurer and insured, and it is the governing document of the plan. In some cases, a more formal plan document or health insurance policy is used as well.

Because it is much more detailed than the SBC, SPDs sometimes consist of hundreds of pages of detailed information about the plan. SPDs should be offered through the insurance company's website, an online exchange, or in-house through an employer's human resources department. Insurance brokers, plan representatives, or human resources personnel will know where to find the SPD if the insured individual cannot locate it. SPDs are also called benefit booklets, certificates of coverage, and insurance policies, depending on the type of health plan.

4. Sorting through the Documents

It is easy to become confused due to the different labels and types of documents used to describe one's health insurance offering. For example, a "Certificate of Coverage" (COC) or "Evidence of Coverage" (EOC) may be the title used to help describe the details of a health insurance policy, in addition to the terms above. This is compounded by the fact that different parties may be responsible for different aspects of the health insurance arrangement (e.g., employer, insurer, plan administrator and any carve-out organizations). And in some cases, the various documents are combined to meet federal and state reporting requirements.

No matter what they are called or who is in charge of them, it is important for individuals to obtain and review the three documents described above, as they will include important information regarding how the appeals process is conducted. This includes important contact information and time restrictions for executing an appeal.

B. How Do Health Plans Manage Care?

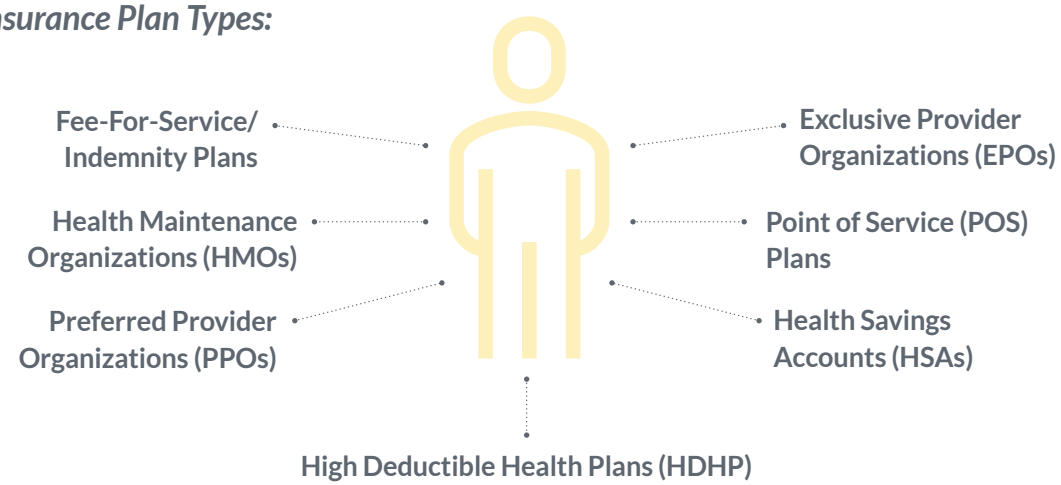
Many different types of health insurance arrangements are available in the United States. An individual's ability to sign up for different types of coverage often depends on where they work. In addition to employer-based coverage, some people purchase individual (or family) insurance coverage through the state-based exchange or individual marketplace. The full range of health insurer options is discussed in more detail below.

A significant factor regarding how any particular health plan is designed and offered is how managed care functions are applied to the plan. Health plans are generally classified according to their managed care network structure, as well as how much freedom a patient has to seek care outside of a

health insurer's contracted network. Elements of managed care include the scope of benefits offered, in-network versus out-of-network coverage, benefit authorization requirements, specialty referral requirements, and the degree of patient cost-sharing through deductibles and copayments.

Before reviewing the explanation of health plan differences below, it is important to remember that no plan is perfect. Every type of health insurance addressed in this Guide has positive and negative attributes, which consumers should take into account.

Insurance Plan Types:



1. Fee-For-Service (Indemnity) Plans

Fee-for-service (FFS) plans allow the covered member to direct their own health care and visit almost any doctor or hospital with no referrals. The insurance company then pays a set portion of the patient's total charges. FFS plans are sometimes referred to as "indemnity" plans. Though the covered members usually choose to get most of their basic care from a single doctor, fee-for-service plans do not require members to choose a primary care physician. However, these plans may require that a member pay for services up front and then submit a claim to the insurance company for reimbursement. In this model, the costs of insurance are primarily determined by the amount of care a member seeks. This type of insurance coverage is now quite rare.

2. Health Management Organization (HMO)

HMOs offer health insurance coverage through a tightly managed network of providers who often act as "gatekeepers," directing access to medical services. HMOs were originally established in the 1970s to allow consumers to have access to preventive care with minimal or no copayments.

HMOs require members to designate a "primary care provider" (PCP) who will be the one point of contact for all health care needs. PCPs are usually generalists (e.g., internists, pediatricians, geriatricians, and family or general practitioners). If the member needs any sort of specialty care, an in-network provider must be utilized. A member's PCP typically must provide a referral to a specialist, and this referral must in turn be authorized as medically necessary according to the HMO guidelines (in some limited circumstances out-of-network referrals may be considered). The HMO can then choose to grant or reject any referral. If they reject the referral, the member can appeal the decision or decide to pay the specialist cost out-of-pocket. Because HMOs are the most tightly managed health plans (i.e. HMOs give members the smallest amount of freedom over their health care decisions), they generally also have the lowest monthly premiums.

3. Preferred Provider Organization (PPO)

PPOs gained popularity in the 1990s as consumers were looking for a health plan option other than HMOs or fee-for-service plans. Consumers wanted the benefits of a network-based plan, but also wanted the freedom to go outside of a specified provider network for specialty care at their discretion.

As a result, PPOs offer a list of providers that the health plan would *prefer* members use and are willing to reward patients with a lower cost for services if they use those providers. These preferred providers are known as in-network providers or preferred providers. PPO plans do, however, allow a member to see any doctor they would like, but doctors not in their network are classified as out-of-network providers or non-participating providers. PPOs will not cover as much of the costs for an out-of-network provider as an in-network provider. Because PPOs give members the option of going in or out of network and do not always require a specialty referral, these types of plans have higher monthly premiums than HMO plans. Ultimately, premium levels also will be impacted by the deductible and copayment levels in each policy.

4. Exclusive Provider Organization (EPO)

EPO plans incorporate some aspects of both PPO and HMO plans. An EPO does not require an insured individual to designate a primary care provider, but it also does not allow the individual to get care outside of its exclusive network. EPOs generally are offered in urban areas or in association with large hospitals, where it is unlikely that a plan participant will need to go to any provider or hospital outside of the exclusive provider organization. Because EPOs give an individual a medium amount of freedom over their health care, they generally have lower premiums than a PPO, but higher premiums than an HMO.

5. Point of Service (POS) Plan

Like EPOs, POS plans are a mix of PPO and HMO plans. A POS plan requires its members to designate a primary care provider, but also allows patients to get care outside of an exclusive network, provided their PCP gives a referral. In the same way as a PPO, if the member does request and receive an out-of-network referral, the POS plan will not pay as much for the out-of-network provider as they would for the member's primary care provider. Similarly to EPOs, POS plans give members a medium amount of freedom over their health care and generally have lower premiums than a PPO, but higher premiums than an HMO.

6. Health Savings Accounts (HSAs)

HSAs are a popular consumer feature that allow individuals and families to invest money for future health care needs in a qualified financial account. HSAs can be used to pay on a pre-tax basis for copays, deductibles, services, and prescription drugs across all plan types, including fee-for-service, HMO, PPO, EPO, and POS plans. HSA contributions, interest or gains on those contributions, and withdrawals are all tax-free, provided the funds are spent on qualifying health purchases. HSA contributions can be withdrawn penalty-free for any purpose after an individual turns 65, although such withdrawals are only tax-free if used for qualified medical expenses.

7. High Deductible Health Plans (HDHP)

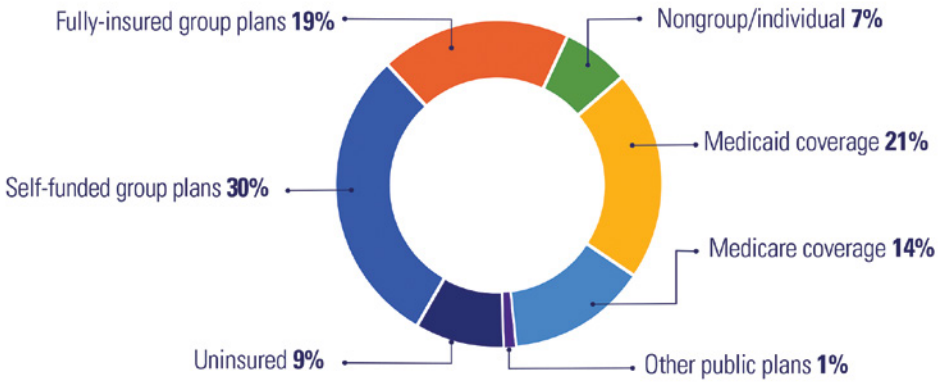
HDHPs are typically offered in conjunction with an HSA. In addition to having a higher deductible than typical health insurance plans, HSA-eligible HDHP plans also have a maximum limit on annual deductible and medical expense costs and do not provide insurance coverage until the deductible is met (except for the following expenses: health insurance premiums, wellness and preventive care, expenses related to accidents, dental expenses, and vision expenses).

HDHP plans offering HSAs generally offer lower monthly premiums in exchange for the much higher deductible, with the understanding that the money consumers save in premium costs will be invested in the HSA. This provides a nest egg for future health care needs with coverage for very expensive, unexpected services.

C. How Are Health Plans Regulated?

The regulatory framework for health insurance is complex and fragmented in the United States. Consumers therefore should understand how their insurance is regulated, because it will impact key aspects of the appeals process when there is a denial of care. In general, it is easiest to remember that the regulation and oversight of the plan will change based on who is sponsoring the plan and who assumes the financial risk of paying for the coverage, as described in more detail below.

U.S. Population Percentage by Health Insurance Market Type



Source: The Kennedy Forum

1. Self-Funded Health Plans

Self-funded health plans are offered through an employer. The Employee Retirement Income and Security Act of 1974 (ERISA) is a federal law that applies to all employer group plans (regardless of whether they are for large or small employers) and offers broad consumer protections and disclosure requirements. ERISA is the primary statute regulating self-funded insurance plans.

In self-funded arrangements, the company or business that offers a health plan to its employees also assumes the risk of funding the insurance plan. This simply means that the money used to pay claims and administer the plan comes from an account owned and operated by the company. The premiums paid by the employees are contributed to this collective pool, which is earmarked solely for the health needs of the company's employees.

Self-funded insurance plans are overseen by the U.S. Department of Labor (DOL) through ERISA. For complaints and concerns about the appeals process in self-funded plans, patients and providers should first contact the employer offering the plan. If the employer cannot resolve the complaint, the DOL's Employee Benefit and Securities Administrator (EBSA) or an attorney can be the next step.

It is important to note that under many self-funded insurance plans, the employer *sponsors* the plan and assumes the financial responsibility, but hires a third-party administrator (TPA) to *operate* the plan. In such cases, the TPA will be a health plan member's point of contact. Often, the TPA is a recognized health plan name such as Aetna, Anthem, United Healthcare, or another insurance entity. In other cases, the TPA may be an organization that just specializes in offering plan administration to a few companies.

There are several reasons for an employer to hire a TPA. TPAs generally have relationships with health care providers and can offer a plan network for plan participants. Additionally, TPAs can take the administrative burden of offering a health insurance plan away from an employer, *including reviewing and responding to member complaints and appeals.* If an individual receives health care through their employer and the employer utilizes a TPA to administer the benefits, it is important to review the individual's SPD to understand the relationship between their employer and the TPA. Particularly important is determining who has the final decision-making power in the appeals process, because complaints and concerns will need to be directed to whichever entity has the final say.

Other examples of self-funded health plans are multiemployer defined benefit plans and multiple employer welfare arrangement plans (MEWAs), which are simply self-funded plans involving more than one employer. Both are subject to the same federal laws that govern other self-funded plans but differ regarding state regulatory oversight. Whereas multiemployer plans are exempt from state regulations, MEWAs may be subject to state oversight depending on how the insurance risk is allocated.

Most multiemployer defined benefit plans, including union and Taft-Hartley plans, are governed by a joint board of trustees with equal representation from labor and management that is responsible for the operation and administration of the plan. The Trustees often hire a TPA to carry out the functions of the plan. As a result, both the Trustees and the TPA share fiduciary responsibility, which means they must act in good faith on behalf of the insured.

MEWAs are insurance arrangements that help market health and welfare benefits to employers for their employees. MEWAs are a way for smaller companies to offer employee benefits outside of traditional commercial insurance options or government-run health insurance exchanges by sharing risk across multiple companies.

2. Fully-Insured Health Plans

Fully-insured health plans are more like the traditional insurance plans mentioned earlier in this section, in which risk is assumed directly by an insurance company. Fully-insured plans can be offered by employers or be individually purchased directly from an insurance agency or through a state-sponsored health insurance exchange.

State regulators have primary oversight of fully-insured plans, but some aspects of the plan may also be overseen by a federal regulator (such as the fiduciary requirements through ERISA). States often have different regulations for fully-insured group plans and individual/non-group plans.

In fully-insured plans, premiums are collected directly by health insurers and claims are paid out of insurance company funding. Because there is an inherent conflict of interest in this arrangement, fully-insured plans are overseen by government agencies. The most common government entity that oversees fully-insured plans is a state insurance department. If patients or providers have complaints about fully-insured plans, they should contact their state insurance offices or other applicable agency.

3. State and Federal Government Health Plans

Government plans are insurance plans that are offered either through a state or through the federal government. Some of the most common government plans are Medicare, Medicaid, and TRICARE.

Medicare is the federal government program that provides health insurance coverage to individuals age 65 or older. Medicare may also be available to persons younger than 65 years of age under certain circumstances, such as people with disabilities. This includes qualified individuals receiving Social Security Disability Insurance (SSDI) and individuals with End-Stage Renal Disease (ESRD). Medicare plans are overseen by the U.S. Centers for Medicare and Medicaid Services (CMS).

Medicaid is a health care program that assists low-income families or individuals in paying for a variety of services, including outpatient visits, hospital stays, and long-term care. Medicaid is a program run by states, in partnership with the federal government. Coverage may vary from state to state. People with disabilities who are approved for Supplemental Security Income (SSI) are eligible for Medicaid rather than Medicare.

Federal Employees Health Benefits (FEHB) plans are offered to federal government employees and their dependents. FEHB plans generally offer multiple plan purchase options, sometimes referred to as basic and standard options. FEHB plans are governed by the U.S. Office of Personnel Management (OPM).

TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the U.S. Department of Defense Military Health System.

Government plans may have different appeal rules and procedures. Depending on which entity issued the plan, complaints and concerns about government plans are usually directed to either the plan itself or the regulatory agency that oversees the plan.

D. What Are the Key Disclosure Requirements?

In addition to understanding how a health plan is regulated, it is equally important to understand what information about an individual's plan must be disclosed upon request. Such information is outlined in federal and state health care laws. It is also important to understand what laws govern a plan's disclosure responsibilities and how an insured individual can assert their rights through an appeal or complaint process when they experience a denial of care from a health insurer.

ERISA requires employer group plans to disclose the plan's "governing documents" to a claimant within 30 days of a request, including the plan's SPD, clinical criteria, and any other documents used to interpret or apply the plan. Additionally, ERISA requires that any benefit notification include the specific reason why care was approved or denied, references to the plan provisions that the determination was based on, and any internal rule, guideline, protocol, or similar criterion that was relied upon in making the determination. ERISA summarizes this information by stating that a health plan is required to provide a claimant copies of all documents, records, and other information relevant to the claim upon request.

The **Health Insurance Portability and Accountability Act (HIPAA)** applies to all plans issued after 1996 and requires health plans and other covered entities to protect health care information related to treatment, payment, and operations. In addition, HIPAA requires health plans to release protected health information to insured individuals upon request, including diagnosis codes and medical records used to review an appeal.

The **Affordable Care Act** established uniform claim and appeal procedures for most group plans and health insurance providers in both the group and individual markets. Among the disclosure requirements required by the ACA's uniform claim and appeal procedure is the requirement that a plan must provide an appellant the reason for denial, a description of the standard used to deny care, and any new or additional evidence considered, relied upon, or generated by the plan in the course of denying a claim.

State-based utilization management and grievance procedure requirements also require fully-insured health plans and other designated health insurer arrangements to disclose key information when a denial of care is taking place, including the reason for the denial and details about the appeals process.

It is critical that consumers understand their rights, which will vary depending on appeal regulations.

E. Who Else Protects Consumers?

Finally, it is important to know that there are other entities that help oversee health insurers. In addition to state and federal oversight, an individual's health insurance policy may be regulated through one or more of the following:

1. Accreditation

Accreditation organizations are non-governmental entities which engage experts to evaluate a health care organization's compliance as compared to predefined performance standards. Accreditation programs focus on process and structure assessments and have been shown to improve clinical outcomes. The use of accreditation helps regulators and purchasers of health insurance more effectively use their resources. Some federal and state agencies recognize or require health plans to be accredited, thereby using accreditation as part of the framework to supplement government regulatory requirements.

More than a dozen accreditation agencies exist to certify different types of health care organizations and a range of functions. Three—URAC, NCQA, and the Accreditation Association of Ambulatory Health Care (AAAHC)—offer accreditation standards impacting how decisions are made during the managed care process. In addition, ClearHealth Quality Institute offers an accreditation program for health plans, TPAs, and others geared to ensure compliance with MHPAEA.

The four accreditation organizations listed above, as well as several others, offer standards addressing the need for written policies and procedures; use of clinical review criteria; time frames for processing different types of reviews; clinical director oversight; privacy and confidentiality provisions; requirements on how to make an adverse benefit determination; details on how to issue a denial notice or appeal rights; instructions on how to process an appeal; guidelines on how to oversee any third-party delegations; and guidelines for quality improvement activities. Most of these requirements directly impact how an insurance company must handle their managed care and appeals process.

While accreditation is optional, once a health plan has become accredited, it must adhere to the applicable accreditation standards and requirements or risk losing its accreditation. For this reason, it is important for consumers to understand what accreditation their health plan holds, and what that accreditation compels their plan to do.

2. The Judicial System

As highlighted throughout this Guide, health insurers are regulated entities. Health insurance coverage is a legal agreement between the member and their health insurer. As a result, the final source of oversight is the U.S. judicial system. Arbitration panels are also sometimes used to settle legal disputes through a private process where disputing parties agree that one or several individuals can resolve the dispute after receiving evidence and hearing arguments. Litigation and arbitration claims filed by plaintiffs can be used to interpret and apply the law. A wide range of issues can be addressed, including ERISA plan fiduciary requirements, MHPAEA and state parity violations, breach of contract claims, and many other types of legal action. Among other illustrative examples, the courts often help resolve disputes over the wording of an SPD when asked to interpret the terms and conditions of health plans. When the courts intervene and fill in gaps or establish new guidelines, this is sometimes referred to as creating a new common law standard.

F. What Happens When Care Is Denied?

Managed care is a fact of the health insurance landscape in the United States. While there are differences in how care is managed, who manages the care, and who ensures that care is managed responsibly, there are thousands of managed care decisions that take place every day. Despite the safeguards put in place by regulators, accreditation organizations, and other oversight bodies, incorrect managed care decisions are made. When a wrong or non-compliant decision is made, plan participants and their providers have the right to challenge that decision through the appeals process.

The remainder of this Guide focuses on what an individual should know before filing an appeal, as well as helpful strategies for drafting an appeal letter.

Part III

What Should Individuals Know Before Filing an Appeal?

Challenging a coverage denial for medical, behavioral health, or prescription drug coverage by a health plan is a legal right guaranteed to all insured people. All plans—including private, individual, and group insurance policies; employer-sponsored health plans; and Medicaid and Medicare plans—must provide a process to review a plan's adverse benefit determination. While all plans must offer an appeals process, the timelines and deadlines associated with that appeals process differ. The insured individual should carefully read the appeal instructions included with any adverse benefit determination and become familiar with the appeal procedure outlined in their SPD.

Before submitting an appeal for benefits, there are a few key things that patients and providers should focus on. First, plan participants and providers should understand how the health insurance appeals process works. As explained in the previous section, they should also understand what type of insurance plan they have, who provides oversight for their plan, and what standards must be obeyed by the reviewer of their appeal. Additionally, plan participants and providers should understand the reason for denial and how to contest each individual denial of coverage. This section will look at each of these issues in depth, as well as some other frequently asked questions concerning insurance appeals.

A. How Does the Appeals Process Work?

The appeals process often differs depending on the nature of the complaint or the denial of care. State, federal, and accreditation agencies also have specific appeal requirements that must be followed. One of the primary purposes of this Guide is to help members figure out what steps to take.

For example, the ERISA regulations applicable to employer-sponsored health plans provide several consumer protections to plan participants who file appeals, including requiring a full, fair, and thorough review of the information submitted for review. Additionally, ERISA requires that if an appeal involves a clinical judgment, the reviewers must consult with a qualified health care professional.

The ACA mirrors the consumer protections outlined in ERISA and requires that all plans issued on or after September 10, 2010 must include an appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
- Gives consumers detailed information about the grounds for the denial of claims or coverage;
- Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
- Ensures a full and fair review of the denial; and
- Provides consumers with an expedited appeals process in urgent cases.

State laws and accreditation standards provide the same due process protection, along with additional requirements such as a "peer-to-peer" consultation between the ordering provider and the medical director associated with the health insurer to discuss the recommended denial of care.

In addition to connecting with the health insurer's appeals office, individuals should also reach out to the state insurance department or other applicable regulatory agency regarding the health plan's consumer appeal protections. State laws governing external reviews vary considerably. It is imperative that patients or their advocates know their rights and responsibilities before filing an appeal.

Insured patients or the treating provider must be informed by the health plan about their rights to file an expedited appeal for urgent cases (such as when there is serious risk to life or health of the claimant or the ability of the claimant to regain maximum function) or a standard appeal for non-urgent cases. Time frames and requirements should be modified accordingly.

1. Where to Start an Appeal?

Health plans are required to have at least one level of internal appeal, and many are also required to offer a second level of appeal. This initial (first) appeal is often called an internal appeal because it is performed by the health plan. The first appeal and any other internal appeals (as required by the health insurer) typically must be exhausted before an external review may be requested.

APPEAL ADVICE

At a minimum, the written appeal should include:

- The individual's name, address, and telephone number
- The individual's insurance identification information, including ID number, group number, and any relevant claim or document numbers
- The provider's name and the date(s) the service was received
- A description of the service or supply the individual is appealing
- A copy of the health plan's adverse benefit determination
- Evidence supporting why the service should be covered, as explained in this Guide

Appeals processing times vary, depending on the type of dispute and the timing of the service in question. Health plans will consider appeals for services that have not yet been received (pre-service appeals), appeals for services that a patient is currently receiving in a hospital or treatment center (concurrent-stay appeals), and appeals for services that have previously been received (post-service appeals). Generally, health insurers process pre-service and concurrent stay appeals more quickly than they do post-service appeals. Some health plans report that they handle the first level of reviews within one business day for services not yet provided, but others may take longer.

Members should check their SPD for the exact response time frames established by the plan—as well as the applicable law for pre-service, concurrent stay, and post-service appeal reviews—and then hold the plan to those time frames. Individuals should also cross-check applicable regulatory and accreditation requirements for their type of health insurance coverage.

If, in the judgment of the treating provider or a health plan medical director, a delay in treatment poses serious risk to the life or health of the claimant, or the ability of the claimant to regain maximum function, an expedited appeal review may be requested. Health plans must respect a patient or provider's request for an expedited appeal, and insurers must establish a process to quickly respond to expedited appeals. ERISA regulations require employer-sponsored health plans to respond to an expedited appeal request within 72 hours, but some plans will respond even sooner. Again, it is important to know the applicable regulations because time frames will vary.

The majority of appeals that are submitted to health plans are post-service appeals, after a medical claim is denied. ERISA and the ACA both stipulate that health plans must allow members at least 180 days from the date they receive the notice of the denied claim to file an initial post-service appeal. Insured members should use the 180 days to gather evidence and arguments necessary for contesting a health plan's adverse benefit determination, as explained later in this Guide.

Depending on the outcome of the first internal appeal, a member may need to file a second internal appeal or seek other actions as directed by their insurance policy. While neither ERISA nor the ACA requires a plan to offer a second internal level of appeal, a second appeal is required in some states and based on some accreditation standards for certain health insurance arrangements. If a health insurer is required or offers a second internal appeal review, the health plan must ensure that the second appeal review is not conducted by the same plan representative who conducted the initial appeal review. Some health plans utilize appeal review panels for the second internal level of appeal, which may include physicians, consumers, or representatives of the health plan.

If a health plan does offer a second level of internal appeal, it is important to determine whether the second level of appeal is mandatory or voluntary. A plan participant must exhaust all mandatory levels of appeals before moving to an external appeal, but they can skip any voluntary levels of internal appeal.

2. What Other Options Do Individuals Have?

If the plan participant, provider, or authorized representative is not satisfied with the health plan's final mandatory internal appeal decision on an appeal involving clinical judgment, they may be eligible to request a separate, external review. The right to an external review is guaranteed by many state laws and the ACA. An external appeal allows consumers to have an independent, third party examine the facts of their case and offer a second clinical judgment.

External reviews are conducted by Independent Review Organizations (IRO), which are required to have no connections or affiliations with the health insurer that denied the care outside of the external review program. However, some consumer advocates have pointed out that since many IROs are selected and reimbursed by the health plans, some indirect bias may exist.

IRO decisions are binding on the insurance company, so if the IRO exercises its clinical judgment and decides that the health plan's denial should be overturned, the health plan must pay for the requested care.

In most cases, an individual must exhaust any internal levels of appeal before seeking an external review. However, in circumstances that warrant an expedited appeal, patients and providers may have the option of requesting an expedited internal appeal and an expedited external appeal at the same time.

Statistics show that external reviews are, on average, more successful than internal levels of appeal, with some states such as California reporting that up to 60% of issues that are appealed to IROs are decided in favor of the member. Despite this success, however, external reviews also have some drawbacks, particularly if an appellant also wants to seek timely legal action against a health insurer for denied claims. In these cases, it is sometimes better to forgo the independent external review and allow the court system to serve as the "independent reviewer" of the denied claims. Each situation is different, however, and it is important to consult with an attorney before making any decision that may affect legal action.

3. What Are the Next Steps If an Appeal Is Not Successful?

When a plan participant has exhausted the internal appeals process (or the external review appeals process), they may be entitled to file a lawsuit against the health plan or the TPA that made the final decision in denying the care. Although the option of seeking legal action can be time-consuming and expensive, there may be situations wherein filing a lawsuit is the final and only recourse for a member to get the coverage they need. Please note that in some limited situations, not all plan types and state laws allow for the pursuit of a lawsuit following exhaustion of the appeals process.

Before making the decision to pursue legal action against a health insurer, it is important to consult with an attorney who is experienced in health care and insurance law. These attorneys can assist in reviewing the individual's plan for important filing dates, venues, and other information. Attorneys also can advise an individual whether or not there are any class action lawsuits pending against the insurer that they may be able to join.

Sometimes, the only way to create change in the insurance industry is through class action lawsuits. Class action lawsuits occur when a group of people, united by a common problem, file a large lawsuit against an insurer. Several recent class action lawsuits have provided more insight into how insurers must treat mental health claims.

A good way to find an attorney who can assist an individual in insurance matters is to reach out to the local state bar association. Patients or their representatives should also explore advocacy resources in their state. A good starting point is to visit the resource page at **www.ParityRegistry.org**.

4. What Should an Individual Do if Their Appeal Rights are Being Violated?

If, at any time throughout the appeals process, an individual feels that their health insurer is not treating them fairly, they have the right to submit a complaint (also known as a grievance). Much like the appeals process, most health insurers have a complaint system (required by law), wherein the individual is permitted to file a complaint and the insurer must respond in a timely manner. Health plans generally provide members with an avenue to issue complaints—not directly related to a denied claim—through an internal resolution procedure, which is handled through the insurer's customer service department.

However, if an individual feels that the issue cannot be addressed by the insurer's customer service department, or simply wants the matter examined by someone outside of the health insurance company, the individual has the right to file a complaint externally.

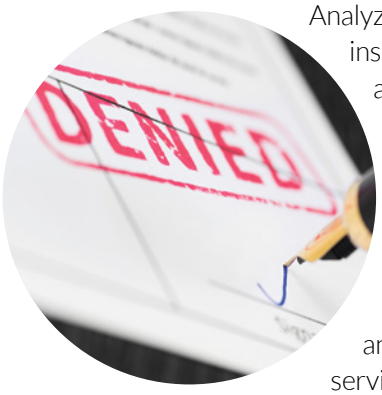
Complaints differ on where they are sent, depending on whether the individual's health plan is fully-insured or self-funded, as discussed in Part II of this Guide. In self-funded plans, complaints should be submitted to the employer's human resources or benefits department, or to the U.S. Department of Labor. Complaints for fully-insured plans should be submitted to a state's insurance regulatory agency, which is headed by the state insurance commissioner. In addition, there may be other avenues to file an external complaint, including the state's attorney general office, accreditation agency, or another authority depending on the individual's type of covered benefit.

Typically, any regulator will try to guide the insured individual in the right direction if they are not sure where to file a complaint. A good place to start is the insured's state insurance commissioner, who will be able to direct the individual to other resources as necessary.

The potential resolutions for complaints also depend on where they are sent. As the plan sponsor of a self-funded plan, an employer can review and overturn any decision made by a health insurer, including a claim denial. In contrast, a regulatory agency charged with enforcing insurance law only allows the applicable regulator to review complaints to ensure that health plans are operating in accordance with the terms and conditions of the insurance policy, as well as with state and federal law. However, regulators can put indirect pressure on the individual's health insurer to address their concerns. In some cases, after a formal investigation, regulators can also fine health insurers or take other legal actions.

Keep these key response options in mind when drafting a complaint letter. For example, if the individual is contacting an applicable regulator, it is a good idea to include a full copy of their SPD. An employer, on the other hand, will already have access to this important plan document, so it will not be necessary to include a copy with the individual's complaint letter.

B. What Processes Are Used to Deny Care?



Analyzing health insurance policies and medical treatment options when making insurance coverage determinations is a complicated process. Many different factors are considered by a health insurer before a coverage determination is made. It is easiest to think about managed care reviews as consisting of one giant checklist of requirements that a member's medical treatment must meet in order to qualify for reimbursement. There are some simple things to check on the list, such as whether the person filing for reimbursement is covered under the plan, and whether or not the provider who rendered services is licensed or otherwise qualified to provide the services they billed. However, there are some items on the list that are far more nuanced, such as whether a patient's clinical circumstances adequately support the need for the specific treatment, or whether the treatment itself is backed by credible scientific research. This more nuanced aspect of the review process is often referred to as utilization review or utilization management.

Analyzing health insurance policies and medical treatment options when making insurance coverage determinations is a complicated process. Many different factors are considered by a health insurer before a coverage determination is made.

While health insurers can deny care for a myriad of reasons on the expansive checklist, the denial reasons can typically be sorted into three overarching categories. While other reasons can be and are used to deny care by health insurers, this Guide focuses on the more common issues. It also offers suggestions on how to apply the broad factors discussed here to the individual circumstances that will arise in each denial of benefits.

As detailed below, there are three overarching categories of "denials." The first two types of denials are related to "administrative" and "coverage" determinations. While they overlap significantly, they are described separately in this document to address several nuances in how the denials should be handled and appealed. The third type of denial described in this Guide is based on a "clinical" determination.

Regardless of denial type, most appeals are directed to one entry point to be registered with the health plan. Individuals should research their particular health plan to know where to file an appeal. The plan participant or their advocate should always review the appeals procedure outlined in the summary plan description (SPD). Once filed, the administrative/coverage appeals are typically handled through administrative plan personnel, whereas clinical appeals are handled through clinical plan personnel. Details will differ between plans and jurisdictions, depending on specifics. So it is always important to review the appeals procedure outlined in the SPD.

1. Administrative Denials

Administrative denials have to do with the administrative processes and procedures of the insurance company. For example, all health insurers use administrative procedures to decide how and when they will accept claims for reimbursement. If a member (or their provider) does not follow this administrative process, the insurer will deny care or the claim for payment, and the member will need to submit an appeal concerning the administrative process. Administrative appeals do not involve clinical judgment or the utilization management process.

2. Coverage Denials

Coverage denials focus on the contractual or legal interpretation of the insurance policy itself and are occasionally referred to as grievances or "appeals within the four corners of the insurance policy." For example, all insurance companies will include a section that outlines what they will and will not cover. However, it is nearly impossible for an insurance policy to list every possible situation or circumstance in which medical care is sought. Occasionally, insurers deny care when they should not, stating that the requested care is not a covered benefit of the plan. When this occurs, a member will need to submit an appeal outlining how the service requested or received meets the terms and conditions of the insurance policy or should otherwise be covered under state or federal law. Coverage appeals also do not involve clinical judgment or the utilization management process.

3. Clinical Denials

In contrast to the first two categories of insurance denials, which can be argued by pointing to objective documents (either a written policy or the terms of the benefit plan), clinical denials focus on a subjective opinion offered by the insurance company—often referred to as a "clinical judgment"— and are typically part of the utilization review process.

The most common type of clinical appeal concerns the medical necessity of a treatment. When a patient seeks treatment for a condition or disease, the member and the treating provider feel that the treatment is medically necessary. As part of utilization management, the health insurer reviews the patient's clinical circumstances and determines if it believes the treatment is medically necessary pursuant to uniform clinical standards. If the insurer agrees that the treatment is medically necessary, it will pay for the care. But if the insurer determines that the care is not medically necessary, it will refuse to pay for care, and a member must appeal the clinical determination.

In some cases (particularly during inpatient stays that last more than 72 hours), insurers will provide an initial determination that care is medically necessary, then change their clinical decision after the patient has been treated for a set number of days. In these situations, plan participants, authorized representatives, or providers have the right to appeal the dates of service that were not covered without jeopardizing the previously approved days. These types of denials are known as "partial denials" of care and are eligible for all levels of appeal like any other adverse benefit determination.

There are other examples of clinical determinations, such as when an insurer determines (in its opinion and clinical judgment) that a service is not safe or effective, or when an insurer determines that a particular type of specialist would be more appropriate to render treatment than another. Because these decisions are subjective in nature, they are often considered more difficult to appeal, as the appeal must attempt to prove that the opinion of an insurer is wrong. However, the opinion-based nature of these denials is also why clinical determinations typically are the only appeals that are eligible to be submitted to an IRO for an independent second clinical judgment of the case.

It is important to remember that each appeal MUST be individualized for the circumstances it addresses. This Guide offers helpful suggestions, including how to leverage the Federal Parity Law, but the success of each appeal in part depends on how well the appeal letter and related documentation advocates for an individual's unique circumstances.

C. Are There Special Circumstances that Individuals Should Keep in Mind?

When filing an insurance appeal, individuals need to understand several key nuances associated with the appeal. Below are a few highlights.

- **When Did the Denial of Care Take Place?** It is important to document when the denial of care took place:
  - Is the plan participant proactively asking for coverage (i.e. prospective review)?
  - Is the plan participant receiving care now (i.e. concurrent review)?
  - Is the plan participant and/or provider seeking reimbursement after the care was delivered (i.e. retrospective review)?

The appeals process will vary depending on when the denial of care occurred.

- **Type of Denial**—As highlighted in this Guide, there are several pathways to file an appeal, depending on whether the denial of care or issue at hand was an administrative, coverage, or clinical denial.
- **Standard versus Urgent Care**—Many states and the federal government require an expedited appeals process when an issue in dispute is for urgent care. Turnaround times are quicker under these circumstances. In addition, some laws provide greater protections for plan participants seeking reimbursement for urgently needed care, even if it is from an out-of-network provider. For example, some laws prohibit health plans from making clinical denials in some urgent care circumstances, requiring the health plan to defer to the judgment of the treating provider.
- **Understanding Appeal Time Frames**—Generally speaking, time frames for health plans to turn appeals around vary dramatically and depend on a wide variety of factors, including the type of insurance the plan participant has, the jurisdiction where they live, and the type of denial. It is important to make sure that the member or their advocate become familiar with each time frame because health plans often miss deadlines. In some instances, when health plans fail to adhere to regulatory-based time frames, this helps in securing additional coverage.
- **Where to File the Appeal**—It is also important to know where to file an appeal, which can change depending on the type of insurance, type of denial, and the stage of the appeals process.

The answers to all of these questions should be outlined in an individual's COC, EOC, or SPD—hence why it is so important to obtain the applicable document(s) before starting the appeals process.

Navigating the Health Insurance Appeal Journey

Source: The Kennedy Forum

Part IV

How Does Mental Health Parity Affect Appeals?

There are special protections that patients can utilize during the appeals process for denials of care related to MH/SUD coverage. The most important of these protections is the Mental Health Parity and Addiction Equity Act of 2008 (also known as MHPAEA or the Federal Parity Law) and any related state parity-based laws. The primary focus of MHPAEA is referenced in its name—the law seeks to help Americans with mental health and substance use disorders by protecting them from discriminatory insurance practices.

A. What Is Parity?

Parity in health care is fundamentally grounded in ensuring mental health and addiction treatment services are delivered at the same level, frequency, and availability as medical and surgical services.

President John F. Kennedy started the conversation about mental health parity more than a half century ago, when he directed the Civil Service Commission in 1961 to offer equal insurance coverage for mental health and "general medical care." Subsequently, mental health parity legislation was introduced in, but not enacted by, eight Congresses. At the time, the concept of parity was limited to coverage for mental health care and did not address addiction treatment benefits. More than 30 years later, the Mental Health Parity Act of 1996 (MHPA) made important strides by requiring the use of comparable annual and lifetime dollar limits for mental health and medical/surgical care.

HELPFUL TIP

Webster's Dictionary defines "parity" as "the quality or state of being equal." Compare your health plan's medical/surgical benefits to your health plan's "behavioral health" or addiction/mental health benefits. Do they appear equal? If not, your plan may not be in compliance with the Federal Parity Law.

The MHPA, while well-intended, contained drawbacks that allowed insurers to continue to discriminate against mental health care. For example, while the MHPA required that insurers have comparable annual and lifetime *dollar* limits for "mental health" and medical/surgical care, the legislation did not address annual and lifetime *visit* limits. Therefore, some insurance companies simply changed their policies from annual and lifetime *dollar* limits to annual and lifetime *visit* limits so MHPA would not apply. Additionally, the law did not address comparable annual or lifetime *dollar* or *visit* limits for "substance use disorders" and medical/surgical care. Despite the efforts of the MHPA, behavioral health coverage still suffered.

MHPAEA attempted to fix these issues when it finally became the law of the land in 2008. While the Federal Parity Law does not require health plans to cover mental health or addiction treatment, it does require parity in designated categories if MH/SUD benefits are offered. Specifically, MHPAEA prohibits covered plans from imposing financial requirements and treatment limitations that are more restrictive for MH/SUD services when compared to medical/surgical services within the designated six benefit categories (as highlighted in Part IV of this Guide).

Similar regulatory requirements exist for Medicaid managed care organizations but with some modifications, since out-of-network benefits are not offered. The ACA extended the protection of parity to individual and small-group insurance coverage and included a provision for Essential Health Benefits (EHBs) that requires MH/SUD benefit coverage by all non-grandfathered individual and small group health plans. The combined reach of MHPAEA, the ACA, and the application of parity in Medicaid plans has touched the health insurance coverage of approximately 174 million people.

Source: The Kennedy Forum

MHPAEA interim regulations were published on February 2, 2010 and the final regulations went into effect on January 13, 2014 for most of the covered plans highlighted in the table below. Over the years, the federal government has published additional regulations and sub-regulatory guidance. Even with this guidance, the Federal Parity Law continues to see challenges in optimizing health plan compliance and regulatory enforcement.

MH/SUD Federal Parity Coverage Requirements

Insurance Coverage Type?	*Applies?*	*Notes*
Commercial Insurance (State Regulated)		
Commercial Large Group Plans: (e.g., plans with more than 50 employees—full-time and part-time employees each count as one employee)	Yes	Pursuant to The Mental Health Parity and Addiction Equity Act (MHPAEA), the Affordable Care Act (ACA), and applicable state law.
Commercial Small Group Plans: Non-Grandfathered (e.g., fewer than 51 employees)	Yes	Technically MHPAEA does not apply directly to small group health plans sold through a commercial market, although its requirements are applied indirectly to non-grandfathered small group plans for plan years beginning on or after January 1, 2014 through the ACA's essential health benefits (EHBs) requirement. Non-grandfathered plans are plans that became effective after the March 23, 2010 passage of the ACA or plans that lost their grandfathered status at renewal by making certain changes in benefit coverage, cost-sharing, or premiums.

Insurance Coverage Type?	*Applies?*	*Notes*
Commercial Insurance (State Regulated)		
Commercial Small Group Plans: Grandfathered (e.g., fewer than 51 employees)	No	MHPAEA does not apply directly to grandfathered small group health plans sold through a commercial market.
Commercial Individual/ Nongroup Plans: Non-Grandfathered	Yes	Technically MHPAEA does not apply directly to individual health policies, although its requirements are applied indirectly to non-grandfathered individual policies for plan years beginning on or after January 1, 2014 through the ACA's EHB requirement. This applies to policies offered both through and outside of the health insurance market places.
Commercial Individual/ Nongroup Plans: Grandfathered	No	Grandfathered individual health insurance policies are not subject to the EHB requirements. However, to the extent that MH/SUD benefits are covered under the policy, coverage must comply with MHPAEA for policy years beginning on or after July 1, 2014 (which, for calendar year policies, is January 1, 2015).
Self-Funded Health Plans (U.S. DOL Regulated)		
Large Employer Self-Funded	Yes	Group health plans for employers with more than 50 employees in which the employer pays for health benefits with its own funds, rather than purchasing health insurance from an issuer, are called self-funded group health plans and are directly covered by MHPAEA, which amended the ERISA.
Small Employer Self-Funded: Non-Grandfathered	Yes	Technically MHPAEA does not apply directly to small group health plans that are self-funded, although its requirements are applied indirectly to non-grandfathered small group plans for plan years beginning on or after January 1, 2014 through the ACA's essential health benefits (EHBs) requirement. Non-grandfathered plans are plans that became effective after the March 23, 2010 passage of the ACA or plans that lost their grandfathered status at renewal by making certain changes in benefit coverage, cost-sharing, or premiums.
Small Employer Self-Funded: Grandfathered	No	MHPAEA does not apply directly to grandfathered small group health plans that are self-funded.
Union/Taft Hartley Plans	Yes	Union-negotiated plans are typically multiemployer defined benefit plans that are governed by a joint board of trustees (Trustees) with equal representation from employees and management. MHPAEA applies directly to Union plans.

Insurance Coverage Type?	*Applies?*	*Notes*
Medicare (CMS Regulated)		
Medicare FFS	No	Not covered by MHPAEA, ACA, or state law.
Medicare Advantage	No	Not covered by MHPAEA, ACA, or state law.
Medicare Special Needs	Yes	MHPAEA does apply to designated special need populations within Medicare.
Medicaid (CMS and State Regulated)		
Medicaid Fee-for-Service state plan only, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP) or Primary Case Care Management only (PCCM) (with no MCO)	No, for MHPAEA Maybe for state parity provisions	MHPAEA does not apply to beneficiaries who receive only FFS Medicaid state plan services or who are enrolled in a PIHP, PAHP, or PCCM but are not also enrolled in a Medicaid Managed Care Organization (MCO). Some states may apply their state parity provisions to its Medicaid FFS offerings.
Medicaid managed care	Yes	MHPAEA is incorporated by legislative reference into Medicaid and is applied to all benefits delivered to members in Medicaid MCOs.
Children's Health Insurance Program	Yes	Same as above for Medicaid expansion of CHIPs. Parity applies to all benefits in separate CHIPs regardless of enrollment in managed care.
Medicaid Alternative Benefit Plans (Medicaid expansion)	Yes	MHPAEA applies to Medicaid benchmark (a.k.a., alternative benefit plans) that are offered by states for Medicaid expansion or coverage of any other group of individuals.
Other		
Plans offered through the health insurance exchanges	Yes	Pursuant to the ACA.
Federal Employees Health Benefits (FEHB) Program	Yes	While MHPAEA does not technically apply to the FEHB program, its requirements do apply through President Clinton's 1999 Executive Order directing implementation of the 1996 Mental Health Parity Act in the FEHB program and incorporation of these requirements, as well as MHPAEA requirements that followed, into the purchasing and coverage standards issued by the OPM.
TRICARE/DOD plans	Similar protections	Although MHPAEA does not apply to TRICARE, the DOD modified the TRICARE regulations to reduce administrative barriers to access MH/SUD coverage for TRICARE beneficiaries.
Veterans Administration	No	Not covered by MHPAEA, ACA, or applicable federal law.

Insurance Coverage Type?	*Applies?*	*Notes*
		Other
Student Health Plans	Maybe	MHPAEA does not apply to student health plans for students operated by colleges or universities. The ACA does apply to some student health plans. A final HHS rule (2014) on this issue indicated that self-funded student health plans could not be included in this regulation without a change in law (for schools that do not pay claims directly but hire an outside insurer, the ACA's EHB requirements would apply). Most college students have the option of remaining on family insurance plans until age 26 (per the ACA), and students who are ineligible for a parental insurance have the option of purchasing individual coverage through the ACA marketplace.
Large Self-Funded State or Local Government Employee Plan	Maybe	Self-funded, non-federal government plans with more than 50 employees may "opt out" of federal parity requirements; state law may require coverage.
Small Self-Funded State or Local Government Employee Plan with less than 50 employees	No	Self-funded non-federal government employers with 50 or fewer employees are not subject to MHPAEA.
Church Plans	Maybe	Because of their ERISA exemption, church plans are not affected by MHPAEA's ERISA requirements. However, to the extent that an ERISA-exempt church purchases a product through a state health insurance exchange, or a state-regulated group insurance product governed by the PHS Act, the product would be subject to parity requirements, unless the church is otherwise exempt under state law.

Source: The Kennedy Forum

B. How Do Insurance Plans Violate Parity?

MHPAEA identifies several types of restrictions used by insurers that violate parity: Financial Requirements (FRs); Quantitative Treatment Limitations (QTLs); and Non-Quantitative Treatment Limitations (NQTLs).

FRs deal with financial limitations on the scope of benefits, such as copays, coinsurance, and deductibles. Common parity violations related to FRs involve the imposition of preferential copays for certain types of medical/surgical providers, but not offering the same preferential copays for any MH/SUD provider types.

QTLs deal with numerical benchmarks, such as whether a plan offers the same number of covered days for MH/SUD care as compared to medical/surgical care. Common examples of QTL violations include if a plan has a lower number of covered visits for mental health care than for medical care. Because QTL violations deal with concrete, comparable numbers, they are generally easy for regulatory bodies to identify and correct.

EXAMPLE

Quantitative Treatment Limitation Example

John's health plan states that it will cover a combined 100 days per year in a mental health inpatient facility.

John's health plan also states that it will provide coverage for inpatient medical/surgical stays, as long as the treatment is medically necessary.

John's plan contains a QTL violation, because the number of reimbursable mental health days is limited, while the number of reimbursable medical inpatient days is unlimited—provided that the care is medically necessary.

NQTLs, on the other hand, address a far broader range of managed care activities. An NQTL is any limit on the scope or duration of a benefit that is not classified as a FR or QTL. This includes nearly every type of managed care activity, including utilization review/management, provider network contracting, and provider reimbursement methodologies. Because NQTLs deal with broad operational and health plan policy issues, they are both much more prevalent and much more difficult to identify and enforce than QTLs.

Concerning NQTLs, the text of the MHPAEA Final Rule states:

> A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, *any processes, strategies, evidentiary standards, or other factors* used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to and are applied no more stringently than *the processes, strategies, evidentiary standards, or other factors* in applying the limitation with respect to medical/surgical benefits in the classification. (Emphasis added.)

This means NQTLs deal with individual insurance processes, strategies, evidentiary standards, and other factors both as they are written and in operation. Another challenge in identifying and proving an NQTL violation is that an insurance company's written processes and strategies for handling mental health claims are often difficult to find. Even with these processes in hand, discerning how they are operationalized can be next to impossible for a consumer. For this reason, MHPAEA places the burden of proving that a plan is in compliance with parity on the insurance plan itself.

MHPAEA requires health insurers to ensure that any covered plan they offer is in compliance. The law also delegates parity oversight and enforcement to individual states. Therefore, states must utilize their insurance office or other applicable state regulatory agency to ensure that plans are complying with MHPAEA requirements. For self-funded plans, the U.S. Departments of Labor (DOL) and Treasury are the primary enforcement agencies.

In addition to indicating who enforces parity, MHPAEA outlines a health plan's parity compliance disclosure requirements.

C. Does Parity Have Disclosure Requirements?

In addition to ERISA, HIPAA, the ACA, and state disclosure requirements discussed in section IV, MHPAEA requires that the criteria for medical necessity determinations be made available to any potential or current members or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement be made available to the plan participant or beneficiary.

Further, the DOL has issued guidance indicating that it interprets ERISA to require that ERISA group health plans must comply with any additional MHPAEA disclosure requirements. The combined disclosure therefore requires ERISA group health plans to disclose an analysis upon request as to why their benefits, including any FRs, QTLs, and NQTLs, are being delivered in compliance with MHPAEA.

EXAMPLE

Non-Quantitative Treatment Limitation Example

Jenny was recently discharged from an inpatient addiction program. Her insurance company said they would not reimburse her care because they do not have any record of her attempting addiction counseling in the last year.

Jenny finds that her plan's benefits for inpatient medical care do not require that a patient visit a general practitioner prior to admittance to a hospital.

Jenny's plan is committing an NQTL violation, since they are requiring that MH/SUD patients try a lower level of care before they admit to an inpatient facility, while not requiring the same for medical/surgical patients.

Importantly, the preamble to MHPAEA's Final Rule offers a reminder that disclosure requirements included in ERISA and the ACA are separate from those required by MHPAEA. While disclosures for the purpose of responding to ERISA or ACA claims may have some overlap with MHPAEA, they are not a substitute for the separate and distinct disclosure requirements of MHPAEA.

These disclosure requirements are important in proving a parity violation, as parity challenges always include a comparison between MH/SUD benefits and medical/surgical benefits. Without the information necessary to compare benefits (which is often solely in the possession of the insurer until it is requested), it is sometimes difficult to properly identify and issue a parity challenge.

D. How Can Individuals Prove a Parity Violation in an Appeal?

Since MHPAEA became law, there have been numerous lawsuits challenging various health insurers' parity compliance activities. The court rulings have identified a number of themes concerning the information necessary to prove that a health insurer has violated MHPAEA. The legal consensus appears to be that, in order to prove a parity violation, a claimant must show, with respect to the applicable insurance policy for the individual:

(1) The insurance policy (a.k.a. the plan type) is covered by the Federal Parity Law;

(2) The coverage provides MH/SUD coverage in addition to medical/surgical coverage;

(3) The FR, QTL, or NQTL is more restrictive for some aspect of MH/SUD care when compared to medical/surgical care; and

(4) The MH/SUD treatment under dispute is in the same classification as the medical/surgical treatment to which it is being compared.

Because this information is crucial to every parity appeal, this Guide examines each point individually, as well as offering general suggestions for utilizing parity regulations in all appeals.

1. Determining if Parity Applies to the Plan

The Table detailing the *MH/SUD Federal Parity Coverage Requirements* above is a good place to start when determining whether a plan is required to comply with MHPAEA.

Remember, it is not enough to simply assert the individual's plan must comply with MHPAEA in order to prove a parity violation. A claimant must explain why parity applies. For example, if the individual is covered by a self-funded, non-grandfathered health plan, the appellant must make sure this is explained in the appeal letter.

Linking the individual's insurance policy to MHPAEA is critical when leveraging these additional appeal rights. Under the Federal Parity Law, the health insurer must disclose additional information to the individual (or ordering provider) related to the parity comparability analysis in response to any potential FR, QTL, or NQTL violations. In addition, any potential parity violation gives another legal reason for a denial of care to be overturned.

If parity does not apply via the Federal Parity Law or an applicable state law, it is important to note that the individual could still leverage their appeal rights under ERISA, the ACA, state law, and other regulatory guidelines as discussed above.

2. Determining if a Plan Offers MH/SUD Benefits

The easiest way to determine whether the individual's plan provides MH/SUD benefits in conjunction with medical/surgical coverage is to obtain the Summary of Benefits and Coverage (SBC). This is an easy-to-read grid, described earlier in this Guide, that every health insurance plan is required to provide to their members. It will indicate whether an individual's plan covers mental health and addiction care, as well as the deductible, copayment, coinsurance, and out-of-pocket maximum for both MH/SUD and medical/surgical care. It may look something like this:

Summary of Benefits and Coverage: What This Plan Covers & What You Pay For Covered Services

Covered Period: 01/01/2018 - 12/31/2018 • Insurance Company 1: Plan Option 1 • Coverage: Family I Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, co-payment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **www.[insert].com** *or call 1-800-[insert] to request a copy.*

Important Questions	*Answers*	*Why This Matters*
What is the overall deductible?	$500/individual or $1,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at **www.healthcare.gov/coverage/preventive**.
Are there other deductibles for specific services?	Yes, $300 for prescription drug coverage and $300 for occupational therapy services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Co-payments for certain services, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, See **www.[insert].com** or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get service.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Source: www.healthcare.gov

Once an individual has examined their Summary of Benefits and Coverage (SBC), it is also important to obtain the plan's documents [including the Certificate of Coverage (COC), Explanation of Benefits (EOB), or Summary Plan Description (SPD)] and compare the benefits listed in the SBC to the plan. The plan will provide additional information concerning not just the benefits available, but how the benefits are provided. While the SBC provides an easy to understand grid that is helpful for identifying QTL violations, the COC, EOB, or SPD are usually more helpful in identifying the coverage details, including potential NQTL violations.

3. Identifying a Limitation

The most crucial part of any parity claim is also the part that is the most difficult to show: identifying a limitation that applies to MH/SUD coverage *which does not also* apply to medical/surgical coverage. It is important to understand that FRs, QTLs, and NQTLs are not violations of the Federal Parity Law in and of themselves. They are common methods of medical management. However, if they are applied *more stringently* to the MH/SUD benefits in the comparable classification than medical/surgical benefits, then this could indicate a parity violation.

Comparison is inherent in the concept of parity because parity is concerned with the state of two separate things being equal. Parity is not concerned with whether an action on the part of a health insurer is good or bad; rather it is concerned, simply, with whether that action has been conducted in a comparable and no more stringent manner to the MH/SUD benefits in a classification in comparison to its application to the medical/surgical benefits in the same classification. Parity takes no stance on how high or low deductible amounts may be, whether health insurer actions are in the best interest of plan members, or what a plan may or may not cover as long as these plan characteristics and practices are equal.

Because comparison is so integral to determining a plan's parity compliance, MHPAEA provides guidance on how to test whether a FR, QTL, or NQTL is applied to MH/SUD in compliance with MHPAEA, and whether a difference in application represents a parity violation.

4. Testing Criteria

Financial Requirements (FRs) and Quantitative Treatment Limitations (QTLs)

MHPAEA assigns mathematical formulas to test whether plans' FRs or QTLs are applied appropriately to MH/SUD compared to medical/surgical care. The information needed for these calculations can typically be found on a member's Summary of Benefits and Coverage. As described below, the testing criteria for determining and comparing a limitation are different for FR and QTLs than the criteria used for NQTLs. Individuals should understand the differences in the parity testing criteria to help show that an unacceptable limitation exists.

The parity testing criteria requires that a FR or QTL must not be applied to MH/SUD benefits unless the FR/QTL type applies to **substantially all** (at least 2/3 of expenditures) medical/surgical benefits in the same category and is no more restrictive than the **predominant level** (the level applied to at least 1/2 of the expenditures subject to the FR/QTL type) of the similar FR or QTL that is applied to medical/surgical benefits in the same category.

Substantially all means the FR or QTL is applied to more than 2/3 of all the plan's anticipated costs for medical/surgical benefits as compared to MH/SUD benefits. In other words, in order to apply a FR or QTL type to MH/SUD benefits in a classification, a plan must apply the same FR/QTL type to at least 2/3 of the anticipated medical/surgical payments in that same classification of benefits.

For example, if a plan anticipates that $1 million in outpatient medical/surgical, out-of-network benefits will be paid, and $700,000 worth of that $1 million dollars will be for benefits subject to a copay attached to it, the plan has applied the copay FR type to more than 2/3 of the outpatient medical/surgical out-of-network benefits. Therefore, it can apply copays to outpatient MH/SUD out-of-network benefits.

The 'substantially all' test identifies whether a plan can apply a FR or QTL type *at all*.

If a plan determines that it applies a FR or QTL type to substantially all benefits in a classification, it must then pass the predominant test. The predominant test identifies what *amount* the FR or QTL type may be.

Predominant Level is any FR or QTL that a health insurer applies to MH/SUD benefits in a classification that is no more restrictive than the predominant FR or QTL that the organization applies to medical/surgical benefits within the same classification. The level of a financial requirement that is considered the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement.

For example, suppose the earlier referenced plan that estimates that $1 million will be spent on outpatient medical/surgical out-of-network benefits, where $700,000 is subject to co-payments, further estimates that $420,000 (60%) will be subject to a $20 copay and $280,000 (40%) will be subject to a $40 copay. In this case, the plan may not impose a copay on outpatient MH/SUD out-of-network benefits greater than $20 because the $20 copay is the predominant (used more than 50% of the time) copay.

This analysis can be very difficult to calculate, as it involves estimates of what future insurance expenses will be. Because of the complexity of this analysis, it is recommended that individuals focus on the **substantially all** test and seek to identify any FR/QTL types that are likely to fail the 2/3 test because they don't apply to very many medical/surgical benefits. Individuals should consider contacting a benefits advisor or parity expert, including the applicable regulator, for assistance with the **predominant** test. Several online tools are also available that might help, including one found at **www.askebsa.dol.gov**.

Non-Quantitative Treatment Limitation (NQTL)

The testing criteria for NQTLs does not use a mathematical formula. Instead, the Federal Parity Law and its regulations state that all processes, strategies, evidentiary standards, and other factors the health plan uses to apply an NQTL type to MH/SUD benefits must be **comparable to and no more stringently applied** than those used to apply that NQTL type to medical/surgical benefits.

The **"comparability and stringency test"** is often more difficult to identify and prove than the **"substantially all and predominant test"**. But there are opportunities to quickly identify whether there has been an NQTL violation in many cases. For instance, if an NQTL type, such as a fail-first requirement or unique referral requirement, is applied only to MH/SUD benefits in a classification and not applied to any medical/surgical benefits in the same classification, this violates MHPAEA. Such violations may be relatively easy to identify.

The Federal Parity Law and its regulations state that all processes, strategies, evidentiary standards, and other factors the health plan uses to apply an NQTL type to MH/SUD benefits must be **comparable to and no more stringently applied** than those used to apply that NQTL type to medical/surgical benefits.

If an NQTL type is applied to both MH/SUD benefits and medical/surgical benefits in the same classification, the full comparability and stringency test is required, which calls for a much more detailed analysis. It is important for a plan participant to utilize their disclosure and transparency rights to gain as much information about the MH/SUD and medical/surgical benefits available under their plan. This information will be crucial in comparing and determining whether a MH/SUD limitation is comparable to a medical/surgical limitation.

Not all NQTLs represent MHPAEA violations, and differences in the imposition of NQTLs for medical/surgical and MH/SUD services may be permissible. *But the presence of an NQTL should raise a yellow flag that the plan may be imposing an impermissible NQTL.*

Many parity resources, including this Guide, provide a non-exhaustive list of health insurer actions that are a warning sign that a parity violation may have occurred. However, the presence of a parity violation *warning sign* is not automatically evidence that a plan has failed to obey parity requirements—a comparison must be made.

With that caveat, here are some common warning signs that a plan may be in violation of MHPAEA.

Common Warning Signs

Common FR/QTL warning signs:

- The number of outpatient MH/SUD visits is limited per year.
- The number of inpatient MH/SUD visits is limited per year.
- The number of MH/SUD treatments covered by the plan is objectively low.
- The plan has a deductible and out-of-pocket maximum only applicable to MH/SUD care.

Common NQTL warning signs:

- *Blanket Preauthorization Requirement:* The plan requires preauthorization for all MH/SUD when a similar blanket preauthorization requirement is not applied to medical/surgical benefits.
- *Medical Management Standards:* The health insurer has standards (including clinical criteria) that limit or exclude benefits based on medical necessity or medical appropriateness—or based on whether the treatment is experimental or investigational—that are more stringent than comparable medical standards.
- *Fail First Protocols:* The health plan states that MH/SUD patients must attempt and fail treatment in a lower level of care prior to admission to a higher level of care; or a patient must attempt a certain number of outpatient visits before being treated as an inpatient. This is also referred to as "step therapy" and can hinder access to certain prescription medications.
- *Probability of Improvement:* The insurer includes an expectation that an inpatient MH/SUD course of treatment is likely to result in improvement or the requirement that a patient show improvement within a certain number of days.

HELPFUL TIP

More warning signs can be found online at **www.dol.gov** and other places. Search "NQTL warning signs" for more examples not included in this booklet.

- *Written Treatment Plan Required:* The health insurer requires that a written treatment plan be created for MH/SUD patients; the written treatment plan must be created within a set number of days after admission; and/or the written treatment plan must be submitted to the insurer on a consistent basis for care to be approved.
- *Patient Non-Compliance:* The plan requires that MH/SUD patients agree with and enthusiastically pursue a recommended course of treatment by a provider.
- *Licensure Requirements:* The health insurer requires that MH/SUD facilities be licensed by the state and accredited by national organizations, but it does not impose the same requirement on medical/surgical facilities.
- *Scope of Service Limitations:* The health plan excludes a MH/SUD treatment or treatment setting based on geographic location, facility type, provider specialty, or other criteria that limit the scope of service available under the plan, but does not impose the same restriction on patients requiring treatment for medical/surgical conditions.
- *Exclusions for Court-Ordered Treatments:* The health plan excludes treatment because the treatment was mandated by a civil or criminal court.

It is important to note that this list is not exhaustive. Individuals should make parity comparisons for all of their MH/SUD care needs, and they should utilize MHPAEA and other federal and state disclosure requirements to determine whether a health plan is in compliance with parity.

Remember, it is the duty of the health plan to report to both the government and their members that the plan is compliant with MHPAEA. It is in the best interest of insured individuals to carefully review the plan documentation, ask questions, and enforce their MHPAEA rights. If something looks like a parity violation, the insured individual should raise the issue with their health plan and demand a meaningful response. If an individual is not satisfied with the health plan's response, then an appeal or complaint should be filed with the health plan.

5. Equivalent Levels of Care Classifications

Finally, MHPAEA requires the parity tests be applied to equivalent levels of medical/surgical and MH/SUD care. MHPAEA identifies six benefit classifications:

- Inpatient in-network
- Inpatient out-of-network
- Outpatient in-network
- Outpatient out-of-network
- Prescription drugs
- Emergency care

NOTE: For Medicaid coverage, four categories of benefits apply: inpatient, outpatient, emergency, and prescription drugs.

This simply means a health insurer should treat MH/SUD benefits no more restrictively than it treats medical/surgical benefits in the same classification. As an example, the policies related to medical/surgical inpatient, in-network care should not differ for MH/SUD patients receiving inpatient, in-network care. A simple way to think of the benefit classifications is that they form the parameters of comparison under parity.

For example, a plan is free to establish a different member coinsurance FR for in-network and out-of-network inpatient benefits for both MH/SUD and medical/surgical services, as they are two separate parameters of comparison. However, a plan cannot establish a more restrictive member coinsurance responsibility for in-network inpatient MH/SUD benefits than the coinsurance applied to in-network inpatient medical/surgical benefits because these benefits fall under the same parameter of comparison.

One of the questions addressed in MHPAEA's Final Rule is the issue of care that does not fall directly into one of the six listed benefit classifications. Specifically, the Final Rule addresses intermediate medical/surgical and MH/SUD care. Intermediate care is care that falls between the intensity of inpatient treatment and standard outpatient treatment. Common MH/SUD examples include residential treatment, outdoor behavioral health programs, partial hospitalization, and intensive outpatient care. Common medical/surgical examples are skilled nursing facilities and rehabilitation hospitals.

The Final Rule clarified that intermediate care benefits were subject to Parity rules, but also stated that new benefit classifications would not be created for intermediate care. Instead, the Final Rule instructed health insurers to sort intermediate benefits into the existing benefit classifications, as well as ensure that:

- Medical/surgical and MH/SUD intermediate benefits are similarly classified into the same benefit classification; and
- Intermediate benefits can be afforded all the same parity protections as any other benefit.

As an example, if medical/surgical care in a skilled nursing facility were classified as an inpatient benefit, then MH/SUD care in a residential treatment facility must also be classified as an inpatient benefit. Regardless of whether a particular type of intermediate care is sorted into a plan's inpatient or outpatient benefits, MH/SUD and medical/surgical intermediate benefits are to be treated equally.

When an individual makes a parity comparison, they should ensure that they are comparing benefits using similar levels of care. As with many other parity questions, if an individual is unsure what benefit classification the requested service or treatment fits into, check with a qualified health care advocate or an attorney.

E. How Can Parity Help with an Insurance Appeal?

MHPAEA can be leveraged to help individuals who believe they are not receiving the MH/SUD care they deserve from their health insurer. While insured individuals can (and are encouraged to) submit parity information requests if they find any plan provisions that may violate MHPAEA, patients and their treating providers should also leverage MHPAEA in appealing adverse benefit determinations related to MH/SUD claims.

First and foremost, plan participants and providers should utilize the disclosure and transparency protections under MHPAEA and other applicable regulations to gather additional information about why a claim was denied. Once a patient or provider has gathered this information, they should carefully examine both the written material of the plan and the actions of the plan reviewer to ensure that no FR, QTL, or NQTL violations have occurred. In many cases, the plan's operations in practice are in violation of parity even if the plan's written policies are in compliance. If a member or provider does not point out and correct these parity violations, the care will ultimately remain denied.

Plan participants and providers should utilize the disclosure and transparency protections under MHPAEA and other applicable regulations to gather additional information about why a claim was denied.

It is also important to raise the issue of parity in case an individual or provider needs to take future legal action against the individual's health insurer. Depending on the laws governing the plan, a parity challenge may not be allowed in a lawsuit unless the internal appeals process was fully exhausted. In many cases, interpreting whether a plan has violated parity will be a determination made by a judge, who will review the arguments and evidence made by the patient or provider during the appeals process.

Finally, parity provides a path to ensure that MH/SUD care appeals are fairly considered and responded to. Many insurance companies currently require MH/SUD patients to display extremely severe symptoms in order to qualify for care, while not requiring the same severity of symptoms for medical/surgical patients. If a claimant does not point out parity violations where they exist, the symptomatic bar necessary to qualify for treatment may never be reached by mental health patients, and health insurers will continue to discriminate against and deny MH/SUD care.

Remember, the burden of proving parity compliance is on the health plan; however, for better or worse, the burden of questioning compliance is the responsibility of the insured member or their advocate. Members and providers should take on this responsibility and diligently inquire as to whether a plan is compliant with parity throughout the internal appeals process.

Part V

Preparing an Appeal—What's Next?

A. How Should an Appeal for an Administrative Denial be Written?

Administrative appeals focus on the process by which a health insurer administers their plan and can be easily summarized as the "nuts and bolts" of the insurance process. For example, all plans include a deadline when coverage requests and appeals must be submitted or specific time frames that preauthorization requests must follow. When these time frames are not followed (or when mistakes are made that cause it to appear that these time frames are not followed), a health insurer will issue an administrative denial.

Because administrative appeals are not matters of clinical judgment, they typically are not subject to the external review process. Instead, most administrative appeals (if not resolved internally with the health insurer) are escalated to either an employer or regulatory complaint. If a complaint about the issue does not succeed, a patient does have an option to move forward to a lawsuit.

A patient can use some or all of the following strategies (as applicable) for success when drafting administrative appeal letters:

1. Understanding the Plan Documents

Individuals should always examine their plan documents, including the SPD, before filing an appeal. The first, and possibly most important, thing to examine is the appeal time frame and submission requirements. The individual, provider, or advocate should ensure that the appeal is being submitted within the appropriate time frame using the correct contact information for the appeal submission. If there are any questions about an individual's appeal rights, they should reach out to the health plan's customer service department or the applicable regulator.

Additionally, the plan should outline all of the administrative procedures for operating the plan, as well as any time frames attached to those procedures. A patient should familiarize themselves with the portion of the SPD the health insurer is relying on for their denial, as well as examine the remainder of the plan documents to determine whether there are exceptions to the administrative process. For example, many plans include a time frame in which claims for reimbursement must be submitted to the plan, but also stipulate that if it is not possible to meet the outlined time frame, a member may submit claims as soon as is reasonably possible.

It is also important to examine the individual's plan documents because insurance policies do not always reflect the individual benefits outlined in the plan. For example, insurance company computers are often programmed to process claims according to the company norm, so any plans or policies that have unique administrative processes may be denied by mistake. In these cases, administrative appeals should quickly resolve the issue.

EXAMPLE

Administrative Appeal Example: Timely Filing of Claims

Mark recently discharged from a 6-month residential treatment stay. The residential program he attended did not file claims to his insurance, so Mark files his own claims the week he leaves the residential program.

Mark's insurance denies his claims, stating that all claims for reimbursement must be filed within 90 days of the date of service.

Mark examines his Summary Plan Description and finds that the Timely Filing of Claims section does have a requirement that all claims be filed within 90 days from the date of service, but notes that for inpatient stays, a patient has 90 days from the final date of service to file claims.

Mark should file an appeal with his insurance company explaining that his stay was inpatient and that he should have until 90 days after his discharge to file claims.

Finally, it is important to investigate whether the plan utilizes a behavioral health carve-out and, if so, to request a copy of the carve-out organization's administrative policies and procedures. In many cases, the name of the carve-out will be listed on the back of the individual's insurance card or referenced on the health plan's website. The internal policies for the carve-out organization and the health plan may differ.

2. Keeping a Record of All Insurance Correspondence

Most administrative denials concern the exchange of information between consumers and their health insurer. To ensure that no mistakes are made, individuals should keep track of and record every phone call, letter, or other communication received by the health plan. Individuals should write down what date the claim was submitted, the name of any person at the health insurer with whom the individual spoke, and what date any appeal letter was submitted.

HELPFUL TIP

Keeping Good Records is Critical

Helpful Suggestions for Record-Keeping

- Decide who in the family will be the record-keeper, or how the task will be shared.
- Set up a file system in a cabinet, drawer, box, binder, or notebook.
- Review all correspondence soon after receiving items for accuracy.
- Save and file all correspondence, including bills, payment receipts, and canceled checks.
- Keep a log of events and expenses.
- Maintain a list of addiction/mental health care team members and all other contact persons with their phone numbers and email addresses. Keep this with your file system.

3. Leveraging MHPAEA

When filing an appeal for coverage reasons, individuals should take advantage of MHPAEA's disclosure and transparency requirements. If a service is denied administratively but nothing in the SPD reflects the reason for the denial, the health insurer may be relying on an internal policy or procedure to deny care. Individuals should ask the insurer for all the policies and procedures used to deny the claim for benefits, as well as the policies and procedures used to deny similar medical/surgical benefits. Then the two sets of policies should be compared.

Additionally, individuals should compare their health plan's appeal and claim filing requirements, as well as any preauthorization requirements. If the plan requires preauthorization for all MH/SUD services but does not require preauthorization for medical/surgical services, it may be violating parity. Similarly, if the plan utilizes a third-party carve-out for mental health claims, and the carve-out organization has separate claim filing requirements for MH/SUD claims than the health plan does for medical/surgical claims, the plan may be in violation of parity.

4. Using Certified Mail and Request a Return Receipt

In the same vein as keeping track of all incoming communication with a health insurer, any written correspondence sent to a health plan regarding an appeal should be sent via certified mail with a return receipt. This will ensure that the correspondence (including appeal letters) is delivered in a timely manner and provide proof that the individual submitted important documents within the specified time frame.

If you are communicating with the health plan through email or an online appeals portal, document all communications.

B. How Should an Appeal for a Coverage Denial be Written?

Coverage appeals primarily focus on the coverage available under the terms and conditions of the plan documents and are not based on clinical judgment. Because coverage appeals focus on the written contract between the member and the health insurer, coverage appeals should focus on the language of the contract or policy itself, as well as any relevant state or federal laws.

Coverage appeals may include a parity violation aspect as well, as it is common for insurance companies to restrict the scope of service for MH/SUD services where they do not similarly restrict the scope of services for medical/surgical benefits. Regarding scope of service, MHPAEA states that the "(s)cope of services generally refers to the types of treatment and treatment settings that are covered by a group health plan or health insurance coverage." MHPAEA restricts insurance companies from discriminating against a mental health or rehabilitation facility based on geographic location, facility type, provider specialty, or any other criteria that would limit the scope of MH/SUD benefits more than analogous medical/surgical benefits. Patients should examine the terms of their plan carefully to determine whether or not health insurers are limiting the scope of services for MH/SUD benefits similarly to medical/surgical benefits.

Because coverage appeals are not subject to clinical judgment, they are not eligible for the external review process. Since coverage appeals typically concern the language of the contract between members and insurers, they are usually decided in the court system or through arbitration if the internal appeals process fails to resolve the dispute. A patient should remember that their coverage appeal may ultimately end up being presented to a judge or arbitration panel. Therefore, the appeal should be drafted in a straightforward and logical manner. It may be a good idea to consult with an attorney or professional health care advocate for assistance in filing coverage appeals.

A patient can use some or all of the following strategies (as applicable) for success when drafting coverage appeal letters:

EXAMPLE

Coverage Appeal Example: Non-Accredited Facility

Elle's daughter is receiving ongoing partial hospitalization program (PHP) services at a highly recommended PHP program that does not contract with her insurance company.

Elle's insurance has denied her daughter's PHP care, stating that the plan only covers PHP programs that are accredited through a national accreditation body.

Elle examines her plan booklet and finds that the terms of the plan do require mental health partial hospitalization providers to be both licensed and accredited by a national body. She also examines her plan's requirements for medical skilled nursing facilities and finds that her plan does *not* require these facilities to be licensed or accredited, but rather to simply be overseen by a registered nurse.

Elle should write a letter to her insurer pointing out that they are requiring higher licensing and accreditation standards for an intermediate mental health benefit than they are for an intermediate medical/surgical benefit.

1. Understand the COC, EOC, or SPD

Individuals should always examine their plan documents, including the SPD, before filing an appeal. The first and possibly most important thing to examine is the appeal time frame and submission requirements. Ensure that the individual's appeal is being submitted within the appropriate time frame and that they have the correct contact information for appeal submissions. If an individual has any questions about their appeal rights, they should reach out to their health plan's customer service department or the applicable regulator.

Because the SPD is the document that controls the plan and is also the document that is under examination in coverage appeals, all arguments should begin with the information included in the SPD. When filing a coverage appeal, a patient should find and examine the plan provision the health insurer is relying on to state a service is not covered. Once a patient has located the exclusion or plan provision an insurer is relying on for denial, they should determine whether the stated exclusion applies to their case. There have been many times when an exclusion is mistakenly applied to a service that it does not apply to at all.

Once a patient has identified the language the health insurer is relying on for denial, they should examine both the coverage section of their plan documents, as well as the definitions section. In many cases, coverage denials are issued because a health insurer misclassifies the treatment received. If an individual finds a provision in their plan that covers the treatment being appealed, reference the page number and include a copy of the page with the appeal.

HELPFUL TIP

When contacting a health plan's customer service line, individuals should make it clear that they are *not* calling to file an appeal. Because appeals can be filed verbally or in writing, phone calls to customer service are sometimes incorrectly classified as appeals.

Individuals should make it clear what information they are requesting and should always ask for the name of the person they are speaking with, as well as a reference number.

2. Understand the Laws Governing Treatment

In the same way MHPAEA protects MH/SUD care at the federal level, many states and localities have passed laws requiring health plans to offer certain MH/SUD or medical/surgical services and may mandate more expansive coverage than federal legislation. If an individual's plan has denied a service, a quick internet search should provide them with information about any laws concerning the issue in question for any mandated benefits. Helpful information can be found at **www.ParityTrack.org** and **www.ParityRegistry.org**. If the individual does not understand how the regulations apply to their plan, they also should reach out to a health care advocate, an attorney, or the applicable regulator for assistance.

Because state and federal law may supersede the terms and conditions of a plan document, the health insurer cannot deny coverage for a service that they are legally obligated to provide. For example, suppose an individual's fully-insured plan indicates that they do not cover residential treatment service for children and adolescents, but there is a state law stating that all plans must cover residential treatment service for children and adolescents. In this case, the terms of the plan must be changed to be in accordance with the law. In fact, many plan documents include a section detailing that they must be in compliance with state and federal law. If a plan document such as an SPD has this section, the individual, provider, or advocate should use it in the appeal letter.

3. Leverage MHPAEA

One of the most important laws to understand and utilize in coverage appeals is MHPAEA. When filing an appeal for coverage reasons, take advantage of MHPAEA's disclosure and transparency requirements. If a service is denied as not a covered benefit, but nothing in the plan states the benefit is excluded, a health insurer is likely relying on an internal policy or procedure to deny care. Individuals should ask the insurer for all the policies and procedures used to deny their claim for benefits, as well as for the policies and procedures used to deny similar medical/surgical benefits. Then the policies should be compared.

In addition, a claimant should examine the scope of service available for MH/SUD benefits and ensure that an insurer is not unduly limiting the scope of service available under the plan. For example, if an insurer indicates that an entire mental health industry (such as intermediate outdoor behavioral health programs or psychological testing conducted by anyone other than a physician) is excluded from coverage, they may be improperly limiting the scope of service of mental health benefits. Any other limitation on geographic location, facility type, or provider specialty that does not similarly apply to medical/surgical benefits is an indication that a plan may not be in compliance with parity.

Similarly, if an insurer has an extensive list of licensing and staffing requirements that an MH/SUD provider must meet in order to be eligible for coverage, but only requires a medical/surgical provider to meet a few requirements, they may be violating MHPAEA or an applicable state law. Remember that individuals should examine not just the written information of their plan, but also the actions of the plan *in operation.* If an individual has any questions, they should ask. Keep in mind that insured individuals have a right to challenge a denial, and it is the responsibility of the health plan to prove that they are not in violation of MHPAEA.

4. Use Certified Mail and Request a Return Receipt

Similarly to administrative appeals, any written correspondence sent to a health plan should be sent via certified mail with a return receipt. This will ensure that the correspondence (including appeal letters) is delivered in a timely manner and will provide proof that the individual submitted important documents within the specified time frame.

If you are communicating with the health plan through email or an online appeals portal, document all communications.

C. How Should an Appeal for a Clinical Denial be Written?

Because clinical appeals revolve around clinical judgment (opinion), clinical appeal letters should leverage evidence and arguments displaying why the insurer's clinical judgment is incorrect or not based on the appropriate clinical criteria.

Clinical appeals should address the facts of the case and the requirements for coverage under the health insurer's benefit booklet or clinical criteria. Additionally, clinical appeals should challenge the health insurer's clinical judgment with the clinical judgment of the treating provider or other experts in the field of care that is at issue. A clinical appeal can also challenge how the health plan applied its clinical criteria or failed to disclose the clinical criteria used in making the denial.

Remember, it is difficult to disprove the health insurer's clinical judgment, so all clinical and professional experts who offer clinical judgment on behalf of the patient should substantiate why their judgment is more relevant than the health insurer's judgment. The most common reasons offered by treating providers as to why they recommend a certain course of treatment often relate to proximity to and/or history of treating the patient in question, but other reasons can include industry expertise, specialties, or other professional accomplishments. Finally, clinical appeals should include the patient's clinical documentation (for medical necessity appeals) or scientific documentation of the services or supplies (for investigational or experimental appeals).

A patient can use some or all of the following strategies (as applicable) for success when drafting clinical appeal letters:

1. Understand the COC, EOC, or SPD

Individuals should always examine their plan documents, such as the SPD, before filing an appeal. The first, and possibly most important thing to examine is the appeal time frame and submission requirements. Individuals should ensure that their appeal is being submitted within the appropriate time frame and that they are using the correct contact information for appeal submissions. If an individual has any questions about their appeal rights, they should reach out to their health plan's customer service department or applicable regulator.

When filing a clinical appeal, find the plan's definition of medically necessary services (or experimental and investigational services, if applicable) and address how the denied service meets the terms and conditions of the plan. If a health insurer's denial of care is contradicted by the language of the individual's plan, it is sometimes an indication that the reviewer who denied care did not perform the full, fair, and thorough review that is required.

2. Letters of Medical Necessity

In order to contest an insurer's clinical judgment, patients and treating providers should offer letters from mental health professionals outlining why the treatment was medically necessary or why the treatment is not considered experimental or investigational. We refer to these letters as "Letters of Medical Necessity."

These letters may be addressed "To Whom It May Concern," but are often more successful when they are directly addressed to the health insurer and discuss the following:

- The mental health professional's history of treatment with the patient;
- (If applicable) An explanation that other courses of treatment were attempted before the treatment in question was pursued;

EXAMPLE

Clinical Appeal Example: Not Medically Necessary

Bill's son, Timothy, was admitted to an inpatient mental health hospital after a suicide attempt. Bill's insurance company approved the first 48 hours of Timothy's treatment, then denied any additional treatment and stated that Timothy was no longer actively suicidal. Timothy's providers disagreed and urged Bill to keep Timothy in treatment for the entire 7 days that were planned.

Bill should appeal this decision, detail the actions that led to Timothy's admission, and state why 48 hours is not a reasonable amount of time for a patient to treat the underlying issues that led to a suicide attempt.

Bill should ask Timothy's providers for assistance and ask that they either draft letters of medical necessity or directly advocate for Timothy to the insurance company, if an expedited appeal is warranted.

Bill should also include Timothy's previous and current medical records in any appeal that he files. He also should examine his insurance's clinical criteria for inpatient mental health care and inpatient medical care to determine any parity violations.

- The reasons why, in the author's professional clinical judgment and/or based on clinical evidence, the patient needed the treatment in question. If the mental health professional is still treating the patient, it is helpful for them to also offer any commentary on the patient's status since receiving the denied treatment; and
- (If applicable) A description of the service and/or treatment and an explanation of why the service in question is not experimental/investigational.

Letters of Medical Necessity should stress the actual, treating relationship the mental health professional has/had with the patient. This part of the letter is important to show the author of the letter has more extensive experience with the patient in question than the insurance reviewer does. Therefore, the letter should emphasize the importance of the recommendation of the treating provider.

3. History of Conditions and Treatment

In cases when a health insurer has denied care as not medically necessary or has stated that care could have been received from an in-network provider, including a history of the patient's symptoms and interventions in the appeal letter can be beneficial. This will allow a health plan reviewer (also known as the utilization management reviewer) to gain a more comprehensive view of the patient's behavioral health history and allows appellants to demonstrate there was a systematic, thoughtful approach to the care in question.

Patient histories can also humanize the patient and provide more detail on the emotional and financial toll of treatment rather than just focusing on the behavioral health and medical symptoms. For this reason, we recommend chronological histories be written by the patient, parent, or close friend/family members who have firsthand experience with the patient. These individuals can explain the real-life consequences that could have occurred if treatment was not secured at the time it was. Because patient histories strive to paint a realistic portrait of the patient before treatment, it is appropriate to include, if possible, copies of social media posts, text messages, and other evidence that demonstrates the mindset of a MH/SUD patient before treatment was sought.

HELPFUL TIP

Keep a log of every telephone call you make with the plan. Be sure to record the date and the name of the person you spoke to, take notes about the conversation, and **request a call reference number.** Keep copies of every document you send to the plan.

Ask what will happen next and when it will happen. If the plan representative says they will have to find out and get back to you, ask when you can reasonably expect a reply and put a reminder on your calendar. Set a reminder on your smartphone if you use one.

If you don't hear from the plan, it's time for another call!

4. Treatment Records

Another key strategy to contesting a health insurer's clinical judgment denial is to submit the medical records of the service in question. These important records supplement the information presented in Letters of Medical Necessity and demonstrate the patient's symptomology at the time of treatment.

Treatment records are also important for any appeal of an extended inpatient stay. Where Letters of Medical Necessity can be limited to the author's interactions with the patient and are often drafted by a referring provider rather than the current treating provider, inpatient treatment records span the duration of denied care. This broad view of care will allow the individual, provider, or advocate to demonstrate that the care was needed on an ongoing basis. This is difficult to show without daily treatment records.

5. Address Clinical Criteria

Most health insurers utilize clinical criteria when making clinical judgment decisions. These criteria are developed internally or by commercial companies like MCG (formerly Milliman) and Change Healthcare (also known as InterQual) and are supposed to be consistent with the generally accepted standards of medical practice for the services and levels of care they address.

One drawback to clinical criteria is that they are written for broad application and do not always apply to every case. Nor are they necessarily consistent with generally accepted standards of medical practice. When addressing clinical criteria, the individual should first determine whether the clinical criteria is superseded by the terms and conditions of their insurance policy. If the clinical criteria do not apply, the individual or provider should point this out in the appeal letter.

Another important concern is to make sure the criteria are in fact consistent with generally accepted standards of medical practice and that the health insurer is properly construing clinical review criteria as applied to the patient's particular case. It is not uncommon for the utilization management reviewer or health plan medical director to not fully understand the specifics of the patient's situation and, as a result, misapply the clinical criteria, leading to an inappropriate denial of care. In the behavioral health context, it is also not uncommon for the utilization management reviewers to adopt improper clinical review criteria and/or ignore their actual contents.

In addition, experts generally agree that clinical criteria may be used as guidelines for providing care, but they stress that clinical criteria cannot replace professional clinical judgment. If a health insurer is placing too great an emphasis on whether a patient meets specific clinical criteria, use the Letters of Medical Necessity and treatment records to show the professional clinical judgment of the rendering provider.

Finally, since clinical criteria are one of the "processes, strategies, evidentiary standards, or other factors" used to limit care, it is important to examine clinical criteria to ensure that no NQTL parity violations are present.

6. Leverage MHPAEA

When filing an appeal for clinical judgment, take advantage of the Federal Parity Law's disclosure, transparency, and plan analysis requirements. The MHPAEA Final Rule indicates that "(m)edical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative" are a warning sign that a plan might include NQTLs that violate parity. The individual's clinical appeal should address how the plan determines that MH/SUD services are medically necessary or experimental, but the individual should also *compare* their plan's process for MH/SUD clinical judgments with medical/surgical judgments.

In many cases, health insurers require a higher (more acute) symptom intensity for admittance and continued care in a MH/SUD level of care than they would for a similar medical/surgical level of care, which is a parity violation. The individual should request their plan's clinical criteria for both the MH/SUD service that has been denied and a similar level of care for medical/surgical within the same benefit classification. The individual should then compare the two criteria and the related processes that the plan uses in making coverage determinations.

For experimental or investigational judgments, compare how the plan determines that medical/surgical services are experimental versus how they determine MH/SUD services are experimental. In some cases, the health insurer will outline that medical or surgical services must be declared experimental or investigational by the U.S. Food and Drug Administration (FDA) or another national accreditation body, while MH/SUD services may be declared experimental or investigational by an internal health committee. Because these standards do not treat MH/SUD and medical/surgical services equally, they may be an NQTL violation.

7. Use Certified Mail and Request a Return Receipt

As with the other types of health insurance appeals, any written correspondence sent to a health plan should be sent via certified mail with a return receipt. This will ensure the correspondence (including appeal letters) is delivered in a timely manner and provide proof the individual submitted important documents within the specified time frame.

If you are communicating with the health plan through email or an online appeals portal, document all communications.

Part VI

Final Thoughts

It is our hope that the information, resources, and other tips found in *The Health Insurance Appeals Guide* is helpful to consumers, providers, and others. While there are significant protections established for consumers through the insurance appeals process, these protections are meaningless unless patients and their advocates challenge improper health insurance denials.

The appeals process is complicated and often daunting for any individual, but is particularly trying for individuals who are already struggling with mental health or addiction challenges. We want to ensure patients have the resources necessary to contact their health insurer, leverage the help of their provider, and ultimately receive reimbursement for the claims they are owed under their health plans.

While there are significant protections established for consumers through the insurance appeals process, these protections are meaningless unless patients and their advocates challenge improper health insurance denials.

We want to hear from you and help if we can! If you believe your insurer has violated your parity rights, we encourage you to register a complaint at **www.ParityRegistry.org**. Sharing your information (which can remain private upon request) helps The Kennedy Forum and other organizations to analyze when, why, and how insurance companies may be illegally denying care. Such data is critical in our ongoing fight for stronger parity legislation to hold insurers accountable. ParityRegistry.org also provides many helpful resources for appeals.

Help us break the silence and bring transparency to a system that oppresses those with mental health and addiction challenges. Become an advocate! Visit **www.DontDenyMe.org** to learn more.

Part VII

Frequently Asked Questions

The following section addresses commonly asked questions regarding health insurance denials of care and appeals.

Do appeals cost money?

Usually not. A health plan cannot charge an insured individual or their treating provider to file an internal appeal. Similarly, there is typically no charge for external review appeals; however, there are a few states that allow charges. Check with your insurance regulator for information on whether there is a filing fee to send your appeal to an external review organization in your state.

How much time should an individual spend writing an appeal?

It depends. The time necessary to write an effective appeal varies and is directly related to the complexity of the case being appealed and the time frame allowed for filing the appeal. In general, administrative appeals and coverage appeals require less evidence and take less time to draft than clinical appeals. However, all appeals should be customized to the circumstances of each individual, and there is no rule about how much time to spend on an appeal letter.

It is important to present all relevant information about the member's behavioral health and medical background to allow the health plan reviewer to fully understand why the care should be covered.

In addition, the individual, provider, or representative filing an appeal must check with the health plan (including the applicable plan document such as the Summary Plan Description) or an appeals expert to make sure they understand the time frame to file the appeal, which can vary dramatically depending on the specific circumstance of the denial of care. For example, an expedited appeal must be filed right away.

How long does my insurance have to respond?

The time varies. In many instances, time frames are established by regulations and accreditation standards. Health plans have different rules about how long they have to respond to an appeal, but all plans generally respond to pre-service or concurrent review appeals faster than they will post-service appeals. Check your individual SPD for appeal response time frames, and do not be afraid to call your insurance regulator if they do not obey the response time frames.

Are there resources to help me draft an appeal?

Yes. Start with *The Health Insurance Appeals Guide* and the *Parity Resource Guide for Addiction and Mental Health Consumers, Providers and Advocates* (The Kennedy Forum/Parity Implementation Coalition 2015). In addition, most states have resources prepared by the state insurance commissioner to guide consumers through the appeals process. If you still have questions, perform an internet search for your insurance commissioner and give them a call.

Some states also offer an ombudsman service that can help you in writing appeal letters or investigating the actions of your health insurer.

Additionally, there are several health care advocacy groups around the nation that assist consumers in filing insurance appeals. These are professional organizations that exist solely to help consumers file appeals and receive reimbursement from their insurance company. A quick online search should give you the name of a health care advocacy firm that can assist you in filing appeals.

Filing an appeal sounds like a lot of work. Is it worth it?

Yes, it is a lot of work, but it is worth it. Many internal appeals of denials of coverage or reimbursement by health insurers are successful in favor of the insured individual and even more external appeals are decided in favor of the person appealing. Just because the process can be long and complicated does not mean it is not worth it. Keeping good records can help simplify the appeals process.

Try not to get discouraged. Often the appeal is not successful at the first level of appeal or even the second. Success is more likely with ongoing and persistent appeals until all options (including legal action) are exhausted. The appeals process will not only help the individual patient, it will help insurers recognize patient needs on a more global scale. In other words, just by taking action, you are helping to enact change.

Does an individual have to appeal a denial before taking legal action?

In most situations, yes. All coverage and claims payment issues must be exhausted through the internal appeals process before legal action may be taken. In most cases, an external review is not necessary before filing legal action, but it is always a good idea to check with your state insurance commissioner or an attorney to determine the steps you need to take in order to file a lawsuit.

Will changing insurance companies or plans hurt my appeal chances?

No. Insurance companies are required to process an appeal as if you were a current member, even if you change insurance companies. As long as you had coverage through the insurance plan at the time of the service, they must honor your legal right to appeal a denied claim.

Part VIII

References

Some of the information found in this Guide is based on the following documents, which are available to download free of charge:

- *Filing an Appeal Based on a Parity Violation: Kennedy Forum Issue Brief* (June 2017). See **www.thekennedyforum.org** (under Resources) or **www.ParityTrack.org**.
- *Parity Resource Guide for Addiction and Mental Health Consumers, Providers and Advocates*, published by The Kennedy Forum and Parity Implementation Coalition (2015). See **www.thekennedyforum.org** (under Resources) or **www.parityispersonal.org** (click on Resources).
- *Utilization Management Regulatory and Market Trends Report: 2016 Annual Report*, published by RegQuest (2016). See **www.regquest.com**.
- *External Review Regulatory and Market Trends Report: 2016 Annual Report*, published by RegQuest (2016). See **www.regquest.com**.
- *The Mental Health & Substance Use Disorder Task Force Final Report*, White House Mental Health and Substance Use Disorder Parity Task Force (2016). See **www.hhs.gov**.

TIP: The quickest way to find these publications is to conduct a Google search with the document title.

About The Kennedy Forum

The Kennedy Forum was founded in 2013 with a mission to lead a national dialogue on transforming mental health and addiction care delivery by uniting mental health advocates, business leaders, and government agencies around a common set of principles. The Forum aims to achieve health equity for all by advancing evidence-based practices, policies, and programming for the treatment of mental health and addiction.

The principles that guide our work include:

- Ensuring health plan accountability and compliance with the letter and spirit of the Federal Parity Law by educating consumers, providers, and regulators, so that each group holds themselves and others accountable for proper enforcement.
- Establishing ways to promote provider accountability through evidence-based outcome measures that are validated and quantifiable.
- Implementing proven collaborative practice models that promote the integration of mental health and substance use disorder services into mainstream health care.
- Using technology to optimize electronic/digital communications and enhance assessment/treatment tools.
- Promoting brain fitness and wellness, which includes identifying opportunities to translate neuroscience research findings into preventive and treatment interventions.

Please visit our website, **www.TheKennedyForum.org** to learn more and sign up for email updates.

About NAMI

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. What started as a small group of families gathered around a kitchen table in 1979 has blossomed into the nation's leading voice on mental health. Today, we are an alliance of 600+ local affiliates and NAMI State Organizations and thousands of volunteers who work in communities around the country.

NAMI's work focuses in three key areas of impact: education and support, advocacy and awareness. NAMI creates, standardizes, researches and updates 10 national education programs, including multi-session education courses, seminars, presentations and support groups that serve close to 500,000 people each year. These programs are designed to empower participants in their mental health journey and teach them the coping skills necessary to support their own recovery or that of a loved one. NAMI shapes national public policy, leading the push for greater investment in research for better treatments, more supports for individuals with mental health conditions and equal coverage for mental health care. Lastly, we fight stigma and raise public awareness about mental health so individuals and families that are affected by mental illness know that they are not alone and there is hope.

Please visit our website, **www.nami.org** to learn more.

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www.thekennedyforum.org

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