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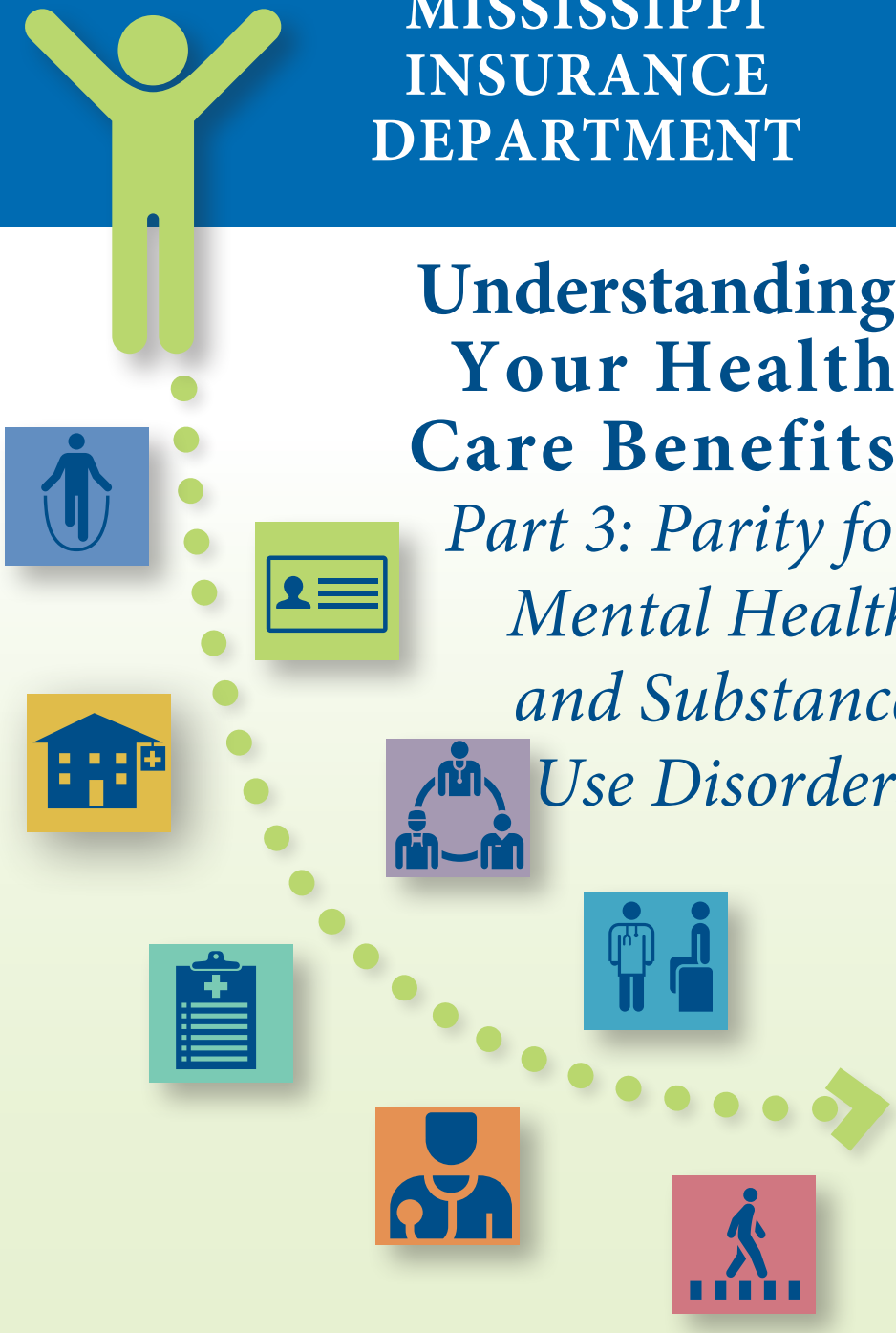

Understanding Your Health Care Benefits

Part 3: Parity for Mental Health and Substance Use Disorders

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Know Your Rights!

There is a federal law that protects the mental health and substance use disorder benefits in your health insurance plan.

How it works:

Read through this short brochure to learn how to make the most out of your mental health and substance use disorder benefits. You'll find helpful examples throughout the brochure, and at the end of it you will find a link to resources if you want to learn more.

Start making the most of your health insurance plan today!

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1 What does the Mental Health Parity and Addiction Equity Act of 2008 do?

Generally, the Mental Health Parity and Addiction Equity Act (MHPAEA or "parity") requires most health plans to apply similar rules to mental health and substance use disorder (MH/SUD) benefits as they do for medical/surgical benefits - otherwise known as "physical health" benefits.

WHAT IS MHPAEA?

We use "MHPAEA" to mean the Mental Health Parity and Addiction Equity Act of 2008.

WHAT IS MH/SUD?

MH/SUD stands for "Mental Health and Substance Use Disorder" benefits found in your health insurance plan.

WHAT ARE MEDICAL/ SURGICAL BENEFITS?

These benefits include coverage for physical healthcare services.

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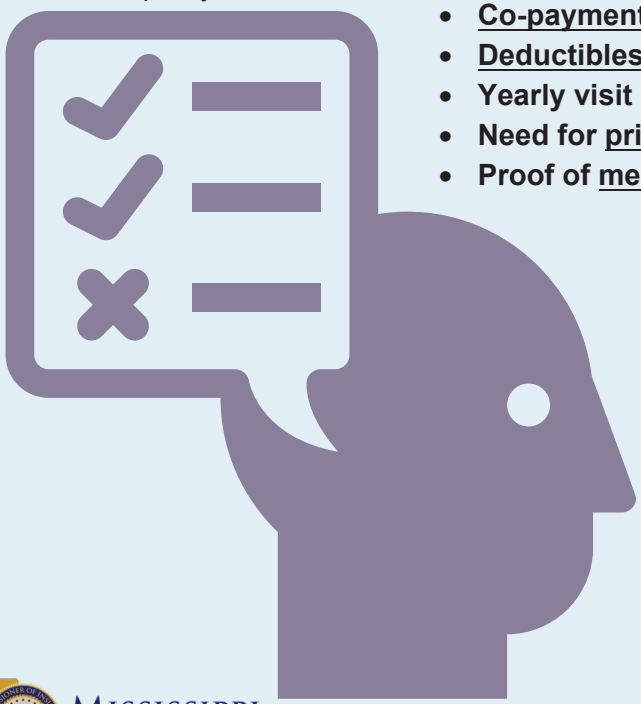
2 What does Parity mean?

"Parity" means equality, or that something is the same as or equal to something else.

Parity here means that financial requirements, such as co-payments, and treatment limits, such as how many visits your insurance will pay for, must be comparable for physical health and MH/SUD services.

Parity also applies to rules related to how MH/SUD treatment is accessed and under what conditions treatment is covered such as whether you need permission from your health plan before starting treatment.

Here are some examples of common limits placed on physical and MH/SUD benefits and services that are subject to parity:



- **Co-payments** (or "co-pays")
- **Deductibles**
- **Yearly visit limits**
- **Need for prior authorization**
- **Proof of medical necessity**

Although benefits may differ across plans, parity requires that the processes related to plan benefit determinations be comparable.

3 What are the potential benefits of MHPAEA?

Here are examples of how the protections from this law may benefit you:

Plans must apply comparable co-pays for MH/SUD care and physical health care.

There can be no limit on the number of visits for outpatient MH/SUD care, if there is no visit limit for outpatient physical health care.

Prior authorization requirements for MH/SUD services must be comparable to or less restrictive than those for physical health services.

4 Which health plans must comply with MHPAEA?

Most health plans are required by law to offer parity for MH/SUD benefits. Generally, these plans include most employer-sponsored group health plans and individual health insurance coverage, including coverage sold in the Health Insurance Marketplaces.

5 What information am I entitled to receive from my health plan?

With respect to parity, your health plan must provide information about the MH/SUD benefits it offers. You have the right to request this information from your health plan. This includes criteria the plan uses to decide if a service or treatment is medically necessary.

If your plan denies payment for MH/SUD services, your plan must give you a written explanation of the reason for the denial and must provide more information upon request.

6 Where do I look for information in my plan about MH/SUD Benefits or parity?

The following are common scenarios that may affect your MH/SUD benefits:

SCENARIO

I am not sure what mental health and substance use disorder treatments my plan will pay for, or if there are limits or exclusions on these benefits.

WHERE TO START

Summary Plan Description and any Summaries of Material Modifications

Summary Plan Descriptions are important disclosure documents prepared by the plan that describe, in understandable terms, the rights, benefits, and responsibilities of participants and beneficiaries.

The Summary Plan Description must include important information regarding the plan, such as information on how the plan works, eligibility requirements, what benefits the plan provides, and how those benefits may be obtained, including how the plan covers mental health and substance use disorder benefits.

The plan's claims procedure, including applicable time frames, must also be included in the Summary Plan Description, or in a separate document distributed with the Summary Plan Description.

Summaries of Material Modifications describe important changes made to the plan and the Summary Plan Description.

WHEN CAN I GET THESE DOCUMENTS?

Summary Plan Descriptions are generally distributed within 90 days after the date a participant first becomes covered by the plan. They also must be provided upon written request, generally within 30 days.

Summaries of Material Modifications that describe an important reduction in covered services or benefits must generally be provided automatically within 60 days of the change taking effect.

SCENARIO

I have a question about the amount my plan pays to an out-of-network provider for mental health and substance use disorder benefits. My plan appears to pay less than what they pay for my out-of-network medical/surgical benefits. I am concerned when I receive a large bill.

WHERE TO START

Plan methods for determining what are called "usual, customary, and reasonable charges" or other methods for determining payments to out-of-network providers.

You can request information on what a plan pays to out-of-network providers and whether these amounts are based on sources such as Medicare rates or a schedule of "usual, customary, and reasonable rates" developed by a third party.

You can request information about:

1. What percentage of these rates or fees the plan pays;
2. Whether the plan relies on the same rates and percentages for out-of-network medical/surgical benefits;
3. Any modifications to the rates or fees when it comes to specific types of mental health and substance use disorder providers (such as psychologists or social workers); and
4. Whether any similar modifications are imposed on specific types of medical/surgical benefits for specific providers and how they are determined.

If the plan relies on its own rates, you may request the studies or other documents that provide the basis for the payments to providers.

Remember, there might be some information that you may not be able to get if the plan deems it proprietary or confidential.

WHEN CAN I GET THESE DOCUMENTS?

Promptly, but generally not later than 30 days after your request.

Shorter time limits apply in the case of urgent care claims.

SCENARIO

I would like to know what mental health and substance use disorder benefits **and** what medical/surgical benefits are subject to preauthorization. My plan says they are all based on clinical utilization review guidelines.

WHERE TO START

Utilization review criteria related to both mental health and substance use disorder and medical/surgical benefits provided under the plan or coverage.

You can request the plan's specific utilization review criteria, and other materials, which could include:

1. Standards developed by an outside organization. Many health plans use third-party standards to determine the level of care required by an individual plan participant;
2. Criteria which may be developed by the issuer or third-party administrator, for both MH/SUD benefits and medical/surgical benefits;
3. Information on how the plan determines when it is appropriate to depart from the criteria developed by an outside organization for both medical/surgical and MH/SUD benefits (if the plan departs from these criteria).

You can also request any analyses the plan has performed to verify whether the plan complies with the MHPAEA.

WHEN CAN I GET THESE DOCUMENTS?

Promptly, but generally not later than 30 days after your request.

Shorter time limits apply in the case of urgent care claims.

SCENARIO

My plan will not authorize a treatment recommended by my health provider (in this case, a specific medication that was prescribed). If treatment is not authorized, my plan will not pay or will reduce payment.

WHERE TO START

The plan's requirement for preauthorization, including utilization review standards, and its medical criteria or "other evidentiary standards, procedures, or strategies" used to develop its utilization review standards.

To determine whether MH/SUD and medical/surgical benefits are being provided comparably, you may request information regarding the basis for determining what MH/SUD and medical/surgical benefits are subject to utilization review. This includes information about the medical guidelines, costs, or other factors supporting the basis for the application of the utilization review standard. This may include the following:

1. Medical necessity criteria;
2. Utilization review standards (*see the previous Scenario*);
3. Other factors related to imposing a utilization review requirement on a particular MH/SUD benefit being sought, such as cost or whether it is considered clinically effective.

For example, plans and insurers often use reports of pharmacy and therapeutics committees to decide how to cover prescription drug benefits. These reports should be requested in order to determine parity in prescription drug benefits.

You also can request any analyses the plan has performed to verify whether the plan complies with MHPAEA.

WHEN CAN I GET THESE DOCUMENTS?

Promptly, but generally not later than 30 days after your request.

Shorter time limits apply in the case of urgent care claims.

SCENARIO

My mental health or substance use disorder claim is being denied.

WHERE TO START

The reason for any denial of payment for services for mental health or substance use disorder benefits.

The health plan or issuer must provide an adverse benefit determination containing:

1. A specific reason for the denial;
2. Reference to the specific plan rules used to make the determination; and
3. A description of the plan's appeal procedures.

WHEN CAN I GET THESE DOCUMENTS?

The time for providing the notice will vary based on the type of claim.

- For urgent care claims, the plan must provide notice within 72 hours of when it received a claim.
- For pre-service claims (i.e., when a service is denied before you receive it), the plan must provide notice within 30 days, with a one-time extension of 15 days allowed.
- For post-service claims (i.e., when a payment for a service is denied after you receive it), the plan must provide notice within 30 days, with a one-time extension of 15 days allowed.
- For concurrent care claims, which involve a determination to continue, reduce, or terminate your current course of treatment previously approved by the plan, the plan must provide notice sufficiently in advance of the coverage termination date to allow you to appeal. Additional rules apply to decisions on requests you make to extend an already approved course of treatment.

SCENARIO

My doctor ordered a certain treatment, but my plan denied my claim. My plan said I must try another, less expensive treatment first. My plan will only consider my claim for the treatment my doctor ordered if the less expensive treatment does not work.

WHERE TO START

Information on the plan's "fail-first" policies or step therapy protocols.

To determine whether the plan's MH/SUD benefits and medical/surgical benefits are being provided comparably, you can request information regarding the basis for determining which mental health and substance use disorder benefits and medical/surgical benefits are subject to "fail-first policies" or "step-therapy protocols."

"Fail-first" policies or "step-therapy protocols" are plan medical management tools. The basis may, for example, be the cost of treatment, medical guidelines, or a combination of factors, but they need to be applied comparably across MH/SUD benefits and medical/surgical benefits.

WHEN CAN I GET THESE DOCUMENTS?

Promptly, but generally not later than 30 days after your request.

Shorter time limits apply in the case of urgent care claims.

7 Do I have the right to Appeal?

If your health plan denies a claim, you have the right to appeal the denied claim.

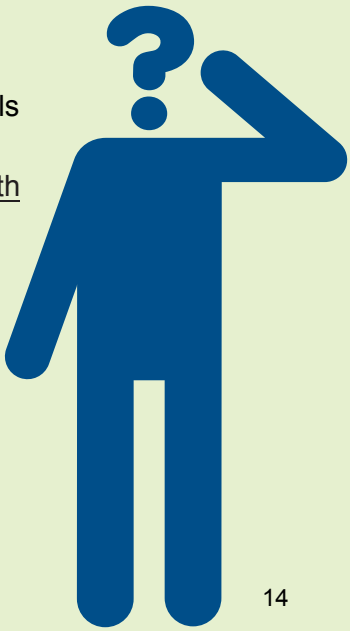
- This means you can ask your health plan to look again at its decision, and perhaps reverse the decision and pay the claim.
- Call your health plan to ask how to submit a request to appeal a claim.

If your health plan still denies the claim after your appeal, MID may be able to review the denial.

- This is called an External Review. It is a free process for consumers where an outside healthcare provider reviews your claim and makes a final decision on medical necessity, appropriateness, healthcare setting, and level of care or effectiveness of the treatment received.
- Requests must be made within 120 days after the denial. Fill out the External Review Request Form here.

To learn more about benefits and the appeals process, go to:

- The HealthCare.gov web page on health insurance rights and protections
- EBSA's web page, Filing a Claim for Your Health or Disability Benefits



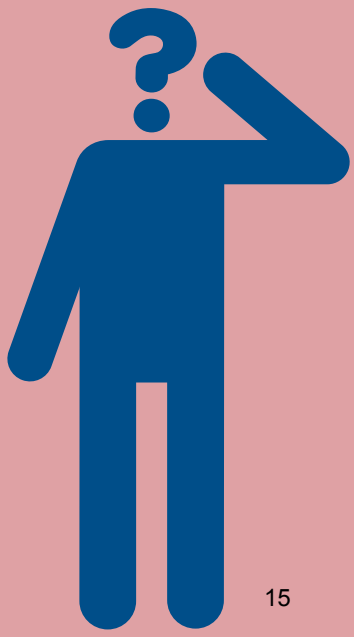
8 How Can I Find Out More?

Call your health plan administrator or Human Resources (HR) representative for the "summary plan description" and the "summary of benefits and coverage."

You can usually find this number online or on the back of your health insurance card.

You may also be able to check your health plan benefits online to see what MH/SUD services are covered.

See if they are comparable to the benefits for physical health.



9 What are the state and federal resources for questions about Parity?

For more about the Federal parity law, go to the Department of Labor (DOL) Mental Health Parity website, or call toll-free at **1-866-444-3272** to speak to a DOL benefits advisor.

You can also go to the Department of Health and Human Services' Center for Consumer Information & Insurance Oversight,or call **1-877-267-2323 ext. 61565**.

For assistance with parity issues from the Mississippi Insurance Department, go to the Department's website, or call toll-free at **1-800-562-2957**.

For additional resources, go to the Substance Abuse and Mental Health Services Administration (SAMHSA) webpage and the Centers for Medicare & Medicaid Services (CMS) webpage.

Mike Chaney

Commissioner of Insurance

and State Fire Marshal

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