



STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

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DIVISION OF SOCIAL JUSTICE
HEALTH CARE BUREAU

**Mental Health Parity Laws:
Ensuring Equal Access to Treatment Coverage**

What are mental health parity laws and how do they work?

New York and federal mental health and addiction parity laws were enacted to require health plans to cover these treatments in a comparable manner as medical/surgical treatment.

Timothy's Law mandates that New York group health plans:

- Provide broad-based coverage for the diagnosis and treatment of mental disorders at least equal to the coverage provided for other health conditions.
- Cover a minimum of 30 days of inpatient care and 20 visits of outpatient care per year for the diagnosis and treatment of mental, nervous or emotional disorders or ailments.
- Calculate deductibles, co-payments and co-insurance for mental health treatment in a manner consistent with medical/surgical treatment.
- Conduct utilization review for mental health benefits in a consistent fashion as for medical/surgical benefits.

New York law also requires that New York group health plans provide coverage for:

- At least 60 outpatient visits in any calendar year for the treatment of substance use disorder, of which up to twenty may be for family members.
- Inpatient substance use disorder treatment, including detoxification and rehabilitation services.

The federal Mental Health Parity and Addiction Equity Act (and regulations under the Affordable Care Act) require that the behavioral health coverage of almost all group, individual and Medicaid health plans be no more restrictive than medical/surgical coverage in 4 key areas:

1. Annual and lifetime dollar limits on benefits.
2. Financial requirements: deductibles, co-pays, co-insurance, and out-of-pocket expenses).
3. Quantitative treatment limitations: limits on the frequency of treatment, number of visits, and other limits on the scope or duration of treatment.
4. Non-quantitative treatment limitations: including utilization review, provider network participation standards, usual, customary, and reasonable amounts, and "fail first" requirements.

Health plan conduct that may suggest violations of mental health parity and other laws:

- Differences between mental health/substance use disorder and medical benefits:
 - Lower annual or lifetime dollar limits for mental health/substance use disorder.
 - Lower day/visit limits for mental health/substance use disorder.
 - Higher co-pays for mental health/substance use disorder, or a separate deductible.
 - Reduced “UCR” reimbursement for visits to a non-M.D. out-of-network provider, if the plan has an out-of-network benefit.
 - Requiring pre-authorization, if not required for medical/surgical benefits.
 - Requiring that the patient “fail first” at other treatments, only for behavioral health.
 - Denying coverage based on failure to complete treatment, only for behavioral health.
 - Denying coverage because the plan concludes that the patient is not going to improve, only for behavioral health.
 - Higher denial rates for mental health/substance use disorder.
 - Excluding coverage for residential treatment, if the plan covers skilled nursing for medical/surgical conditions.
- Insufficient and/or incorrect information in coverage denial letters:
 - No description of the clinical rationale the plan used in making its decision.
 - No information about the credentials of the reviewer who issued the denial.
 - No information about the criteria and evidence the plan used in making its decision.
 - No description of procedures, timeframes, and consumer rights for grievance and appeal.
- Use of incorrect criteria. For example, a plan should not deny coverage for substance use disorder rehabilitation due to lack of withdrawal symptoms if that is not a criterion.
- Failure to consult with the patient’s provider.
- Failure to consider medical evidence provided.
- Refusal to provide the plan’s medical necessity criteria.

Resources

**Office of the Attorney General
Health Care Bureau**

Consumer Helpline: (800) 428-9071

Complaint Form and Other Information:

<http://www.ag.ny.gov/bureau/health-care-bureau>

New York State Department of Financial Services

Consumer Hotline: (800) 342-3736

External Appeal Information and Form:

<http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>

United States Department of Labor

Employee Benefits Security Administration

Telephone: (212) 607-8600

Complaint Form: <https://www.askebsa.dol.gov/WebIntake/Home.aspx>

How to protect your patients' rights:

- Request authorization from your patient's health plan **before** treatment, if required.
- For each coverage request, review a copy of the health plan's medical necessity criteria and explain to the plan why the patient meets them (point-by-point), and submit medical records.
- Know the plan's decision response deadlines:
 - Pre-authorization reviews: 3 business days/72 hours.
 - Continued treatment/inpatient substance use treatment reviews: 1 business day/24 hours.
 - Retrospective reviews: 30 days.
- For each contact with the health plan, ask for the name, title and ID number of the rep, noting the date, time, and what the person said, and ask for written confirmation.
- If you (or your patient) receive a denial:
 - Check the facts about your patient's condition in the plan's denial letter for accuracy, and let the plan know about any mistakes as soon as possible.
 - Submit a letter of medical necessity, including facts that show that your patient meets the relevant medical necessity criteria, point-by-point.
 - Ask (in writing if possible) the health plan for the following, which they must give you:
 - A written, detailed explanation of the reason for the denial.
 - A comprehensive set of plan documents and the patient's claim file, including copies of all documents, records, and other information relevant to the claim for benefits.
 - Documents comparing the plan's medical necessity criteria and utilization review for medical/ surgical benefits and mental health and substance use disorder benefits.
 - Confirmation that the plan's criteria match the level of care, are based on generally accepted practices, and for substance use disorder, have been approved by the New York Office of Alcoholism and Substance Abuse Services (OASAS).
 - A description of the qualifications of the reviewer who issued the denial, and confirmation that they have the same specialty as you.
- File (orally or in writing) an appeal on behalf of your patient, as their designee:
 - Internal Appeals – if New York plan doesn't meet deadline, decision is deemed reversed:
 - Expedited: for continued treatment or when you believe an immediate appeal is warranted, the plan must decide within 2 business days. For inpatient substance use disorder treatment, the plan must decide within 24 hours.
 - Coverage pending decision: The Affordable Care Act requires health plans to continue coverage pending completion of internal appeals. For New York plans, for inpatient treatment for substance use disorder, the plan may not deny coverage while a decision is pending if an appeal is submitted at least 24 hours prior to discharge.
 - External "Independent" Appeals
 - Generally available for medical necessity denials, experimental treatment exclusions, and out-of-network denials.
 - Expedited: if you state that a delay in providing treatment would pose an imminent or serious threat to the patient's health, the appeal must be decided within 72 hours.
- Do not enter into a "self pay" arrangement with your patient until after the appeals process has been completed. Otherwise, you may be responsible for the cost of treatment.