

Health Law Advocates' Mental Health Parity Toolkit

HEALTH LAW ADVOCATES

Health Law Advocates (HLA) is a non-profit, public interest law firm that provides free legal help to low-income Massachusetts residents having trouble accessing or paying for health care services. We help people who try to sign up for health insurance but are denied and people who have health insurance that refuses to cover a particular health care service. We also assist people subjected to unfair health care billing or collections. Since HLA's creation in 1996, we have fought to get our clients coverage for treatment of mental health conditions and substance use disorders. This work, including the creation of this guide, is conducted through HLA's Mental Health and Addiction Parity Initiative.

HOW TO USE THIS TOOLKIT

This Toolkit is meant to assist consumers, providers, advocates, family members and others who need to obtain insurance coverage for mental health or substance abuse services and/or want to learn about the laws that require health insurers to provide such coverage. The Toolkit includes information about what to do if a health insurer denies coverage. The Toolkit also provides an overview of the laws that require health insurers to cover mental health and substance abuse treatment which are known as the "Parity Laws." Lastly, the Toolkit includes a glossary of helpful terms, an appeal letter template, and other resources. We welcome your feedback on the Toolkit; please use the feedback form available at www.healthlawadvocates.org or send your comments to: etabor@hla-inc.org.

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PARITY TIMELINE

1996 — Mental Health Parity Act (MHPA)

Large employers prohibited from placing higher annual or lifetime dollar limits on mental health benefits than on physical health benefits.

2000 — An Act Relative to Mental Health Benefits (Massachusetts Parity Law)

Mandates coverage of specific mental health conditions and substance use disorders in health insurance policies issued or renewed in Massachusetts.

2008 — Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Federal Parity Law)

Health plans that offer benefits for mental health conditions or substance use disorders must cover such conditions/disorders in a comparable manner to physical health conditions.

2010 — The Affordable Care Act (ACA)

Essential Health Benefits required in individual and most small employer plans include benefits for mental health and substance use disorders subject to the Federal Parity Law.

2013 — Final Federal Parity Rule for Private Health Plans

Explains in detail the rules that private health plans must follow to comply with the Federal Parity Law.

2016 — Final Parity Rule for Medicaid and Children's Health Insurance Program (CHIP) plans

Explains in detail the rules that certain Medicaid and CHIP plans must follow to comply with the Federal Parity Law.

INTRODUCTION TO PARITY

Historically, insurance plans covered treatment for mental health conditions less generously than treatment for physical health conditions. Parity is about making health plans treat individuals with mental health conditions fairly. Because of federal and state parity laws, most insured Americans are now entitled to receive Mental Health and Substance Use Disorder (MH/SUD) benefits on a comparable basis to benefits for other conditions.

FEDERAL MENTAL HEALTH PARITY LAWS

The Mental Health Parity Act (MHPA)

Passed by Congress in 1996, the MHPA requires limited parity for mental health benefits in large employer group plans (employers with more than 100 employees). The MHPA prohibits large employer plans that include mental health benefits from having lifetime or annual dollar limits for mental health benefits that exceed any limits the plan has for physical health benefits. The **Affordable Care Act (ACA)** bars lifetime and annual dollar limits for MH/SUD benefits that are covered by small group and individual plans as **Essential Health Benefits (EHB)**. To learn more about Essential Health Benefits see the Glossary or visit www.cms.gov/cciiio/resources/data-resources/ehb.html.

Mental Health Parity and Addiction Equity Act (Federal Parity Law)

Congress passed the Mental Health Parity and Addiction Equity Act (**Federal Parity Law** or MHPAEA) in 2008. The Federal Parity Law is a landmark law that has already improved access to mental health and substance use disorder services and has the potential to do a

IS MY PLAN FULLY INSURED OR SELF-INSURED?

In a *fully insured* group health plan the employer pays a monthly premium to an insurance company and the insurance company takes the financial risk for all claims filed. This is what we typically think of as insurance.

In a **self-insured** (or **self-funded**) group health plan the *employer* has financial risk for claims filed under the plan. Employers that self-insure are usually large companies or organizations, including labor unions.

Getting an “insurance” card does not mean your plan is fully insured since self-insured plans often hire insurance companies to manage plan benefits. Ask your Human Resources department what kind of plan you have. Even better, read the **Summary Plan Description (SPD)**, which has to describe how the plan is funded. You have a right to get the SPD within 30 days of a written request.

lot more. The Federal mental health parity laws do not mandate that a health plan include MH/SUD benefits, but if a plan does offer these benefits it must do so in a comparable manner to benefits for physical health (medical/surgical) conditions. The Law says that mental health and substance use disorder benefits, if included in a health plan, must be covered in comparable ways, with no more restrictive **financial requirements** or treatment limitations. The Federal Parity Law applies to many, though not all, kinds of health coverage that people may have. Turning the Law’s complex rules into practical protections for real people is challenging but progress continues to be made.

Health plans covered by the Federal Parity Law

The kinds of plans that must comply with the Federal Parity Law are:

- **Group health plans** of private employers with more than 50 employees. This includes so-called *self-insured* group plans. (See box at left for an explanation of “self-insured.”)
- **Non-grandfathered small group health plans** (plans sponsored by employers with fewer than 50 employees) and individual health plans, including plans sold through the Federal and State health insurance marketplaces. These plans must offer “Essential Health Benefits” including mental health and substance use disorder benefits. In Massachusetts the insurance marketplace is the Health Connector. (See Glossary for more information on Essential Health Benefits.)

WHAT IS A GRANDFATHERED PLAN?

A **grandfathered plan** is a health plan that was in effect on March 23, 2010 and that has not changed substantially since that date. A plan that claims to be grandfathered must say so in the plan documents.

Some small group and **individual health plans** are **transitional** and exempt from certain parts of the Affordable Care Act. Small group transitional plans are exempt from the Federal Parity Law but individual transitional plans are not. No new transitional plans can be created and existing plans will end by December 31, 2017.

- *State and local government employer plans that have not opted out of the Federal Parity Law.* Self-insured non-Federal governmental employers may opt out of the Federal Parity Law. (**Fully insured plans** for state and local government employees must comply with the Federal Parity Law.) To opt out, a state or local government employer must meet certain requirements set by the federal government. An election to opt-out applies for a single year, except for a plan provided pursuant to a collective bargaining agreement for unionized employees, which covers all years included in the agreement. The state or local government employer must issue a notice of opt-out to enrollees before the plan year begins, at the time of enrollment and on an annual basis, and must notify the federal government each year. The **Group Insurance Commission (GIC)**, which covers all state and many local/municipal employees in Massachusetts, has not elected to opt out and is therefore subject to the Federal Parity Law.

*The above plans—large and non-grandfathered small private employer-sponsored, individual and non-Federal governmental—are subject to the **2013 Final Parity Rule**.*

- Certain Medicaid plans — In Massachusetts, **MassHealth** Managed Care Organizations (MCOs), the MassHealth Alternative Benefit Plan (CarePlus) and the **Children's Health Insurance Program (CHIP)** are subject to the Federal Parity Law. Many MassHealth members without other insurance enroll in an MCO for their coverage. (The other option for these members is the Primary Care Clinician Plan.) Adults under 65 without children whose income is no more than 133% of the Federal Poverty Level (FPL) may qualify for CarePlus. The CHIP plan is MassHealth Family Assistance for child members with household incomes between 150% and 300% of the FPL. **The 2016 Final Medicaid Parity Rule applies to these MassHealth plans.**

Plans exempt from the Federal Parity Law

Some kinds of health plans do not have to comply with the Federal Parity Law. These are:

- *Retiree-only plans*, which an employer offers exclusively to retirees, not active employees
- *The Federal Employees Health Benefit (FEHB) Program* — **FEHB** plans must offer coverage for the diagnosis and treatment of recognized mental health conditions and substance use disorders. While the Federal Parity Law does not apply to the FEHB Program, the Office of Personnel Management, which runs the FEHB, has decided to apply the Law's requirements to coverage offered through the FEHB Program.
- *TRICARE* — **TRICARE** is the health insurance program for Uniformed Service members and National Guard/Reserve members and their families and certain others shown as **eligible** in the Defense Enrollment Eligibility Reporting System (DEERS). TRICARE is not subject to the Federal Parity Law. However, recently TRICARE implemented significant improvements to its MH/SUD benefits. More information about TRICARE mental health coverage is available at tricare.mil/CoveredServices/Mental.aspx.
- *Medicare* — Medicare does not offer parity between mental health benefits and physical health benefits. However, the coverage Medicare provides for mental health treatment has improved in recent years. For example, coverage under Medicare Part B for outpatient counseling and therapy has increased to 80 percent of charges from only 50 percent of charges a few years ago. For more information about Medicare benefits visit www.medicare.gov.

Federal Poverty Level (FPL) 2016*	
Family Size	Annual Income
1	11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

*The Federal Poverty Level is updated every year.

MASSACHUSETTS STATE PARITY LAW

An Act Relative to Mental Health Benefits (Massachusetts Parity Law)

Passed in 2000 and amended in 2008, the **Massachusetts Parity Law** mandates coverage of specific mental health conditions and substance use disorders in health insurance policies issued or renewed in Massachusetts and in plans for state and municipal employees through the Group Insurance Commission (GIC). So, unlike the Federal Parity Law, the Massachusetts Parity Law does require affected health plans to include certain mental health benefits. The Massachusetts Parity Law applies only to *fully insured* private health

plans, whether sold to groups or individuals, and GIC plans. (See box on **page 4** for an explanation of **fully insured**.) All plans available through the Massachusetts Health Connector are fully insured private health plans covered by the Massachusetts Parity Law. The Law does **not** apply to:

- *Self-insured* private employer group health plans
- Medicaid (MassHealth)
- Medicare
- The **Federal Employees Health Benefits (FEHB) Program**
- TRICARE for military employees

Nondiscriminatory coverage must be offered for “biologically-based” mental conditions

Under the Massachusetts Parity Law, fully insured private and GIC plans must cover on a *nondiscriminatory basis* the diagnosis and treatment of specified “biologically-based” conditions. **Nondiscriminatory basis** means that any annual or lifetime **dollar or unit of service** (e.g., number of outpatient visits, inpatient days) limitations **may not be less** for the protected mental health conditions than any dollar or unit of service limitation imposed on coverage for physical conditions. In addition, **copayments, coinsurance and deductibles cannot be greater** for biologically-based mental disorders than for physical conditions.

There are 13 biologically-based mental health conditions (or categories) identified in the Massachusetts Parity Law:

1. Schizophrenia
2. Schizoaffective disorder
3. Major depressive disorder
4. Bipolar disorder
5. Paranoia and other psychotic disorders
6. Obsessive-compulsive disorder (OCD)
7. Panic disorder
8. Delirium and dementia
9. Affective disorders
10. Eating disorders
11. Post-traumatic stress disorder (PTSD)
12. Substance use disorders
13. Autism

An Act Relative to Insurance Coverage of Autism (ARICA), passed in 2010, expands and clarifies the scope of mandated insurance coverage for diagnosis and treatment of autism spectrum disorders under Massachusetts law.

Special parity rights for children

Under the Massachusetts Parity Law, children up to age 18 are entitled to coverage on a nondiscriminatory basis for the biologically-based conditions listed above and for:

- Mental, behavioral, or emotional disorders that **substantially interfere with** or **substantially limit** functioning and social interactions.
- For parity coverage to apply these disorders must be:
 - Documented by a primary care **provider**, pediatrician, or licensed mental health professional; or
 - Evidenced by conduct (for example, the inability to attend school, the need for hospitalization, or a pattern of behavior that endangers the child or others).
- Health insurance plans must continue to provide coverage for an ongoing course of mental health treatment for a mental, behavioral or emotional disorder as defined here which begins before the child turns 19 and continues through the child's 19th birthday, until the course of treatment is completed.

A full range of services must be covered

Under the Massachusetts Parity Law, health plans must cover a full **range of services** for adults and children, including **medically necessary inpatient, outpatient, and intermediate services**.

Intermediate services required to be covered, if medically necessary, include:

- Acute and other residential treatment
- Clinically managed detoxification services
- Partial hospitalization
- Intensive outpatient programs
- Crisis stabilization
- In-home therapy

The Massachusetts Parity law remains helpful protection for members of fully insured health plans after passage of the 2008 Federal Parity Law and the Affordable Care Act. That's because the Massachusetts Parity Law mandates specific benefits and coverage where the Federal Parity Law does not. The ACA requires mental health and substance use disorder benefits (considered Essential Health Benefits) in individual and most small group plans. The three laws together provide strong protections for Massachusetts residents covered by an insurance plan.

NO PREEMPTION BY FEDERAL PARITY LAW

The Federal Parity Law does not override or replace ("preempt") the Massachusetts Parity Law. State insurance laws that do not conflict with the Federal Parity Law remain in full effect.

WHICH LAW APPLIES?		
	MA Parity Law	Federal Parity Law (MHPAEA)
Large group, self-insured	No	Yes
Large group, fully-insured	Yes	Yes
Small group, fully-insured	Yes	Yes ¹
Small group, self-insured	No	No
Individual (non-group)	Yes	Yes
State employee plan (GIC)	Yes	Yes
Massachusetts local government employee plan (non-GIC)	Yes ²	Yes ²
Medicaid/MassHealth	No	Yes ³
Medicare	No	No
TRICARE	No	No ⁴
FEHB Program	No	No ⁴
¹ Except grandfathered plans. ² The MA and Federal Parity Laws apply to <i>fully-insured</i> local government employee plans; the Federal Parity Law also applies to <i>self-insured</i> local government employee plans unless they opt out. ³ Managed Care Organizations, CarePlus, and Children's Health Insurance Program plans. ⁴ The FEHB Program offers parity in mental health and substance use disorder benefits to the extent required by the Office of Personnel Management. Similarly, TRICARE has made its benefits more parity-compliant.		

HOW THE FEDERAL PARITY LAW WORKS

The Federal Parity Law protects most Americans with health coverage by requiring “parity” between mental health and substance use disorder (MH/SUD) benefits and benefits for medical and surgical care (medical/surgical). These protections take 3 forms:

- Financial requirements
- *Quantitative* treatment limitations (QTLs)
- *Non-quantitative* treatment limitations (NQTLs)

Benefit Classifications

To figure out whether a private plan complies with the Federal Parity Law, MH/SUD and medical/surgical benefits must be compared within 6 **classifications** or categories:

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

Most plans have contracts with certain health care providers and facilities. These providers and facilities are referred to as “in-network.” However, if a plan does not contract with a network of health care providers, all benefits are considered **out-of-network**. By contrast, the out-of-network categories rarely apply to HMO plans because these plans generally do not allow members to see health care providers outside of the limited network. Also,

for Medicaid (MassHealth) plans only 4 classifications are used: inpatient, outpatient, emergency care, and prescription drugs.

A plan is allowed to sub-divide the outpatient categories into 2 subgroups — 1) office visits and 2) all other outpatient services.

Plans that have multiple “**tiers**” of providers with different cost-sharing levels for members are allowed to sub-divide the in-network inpatient and outpatient categories into tiers. But the plan must assign tiers based on reasonable factors and without regard to whether the provider offers mental health/substance use disorder services or medical/surgical services.

Plans may apply different levels of financial requirements, usually copayments or coinsurance, to different tiers of prescription drug benefits, if the tiers are based on reasonable factors such as cost, effectiveness, generic versus brand, and mail order versus pharmacy pick-up.

IMPORTANT

A health plan cannot offer benefits for mental health conditions or substance use disorders in fewer categories than for medical and surgical conditions. So if a health plan covers MH/SUD benefits in any category, the plan must cover MH/SUD benefits in all categories in which medical/surgical benefits are covered.

Financial requirements

Under the Federal Parity Law, financial requirements for MH/SUD benefits must be **no more restrictive** than financial requirements for medical and surgical benefits. Financial requirements are defined as deductibles, copayments, coinsurance and **out-of-pocket maximums**.

A health plan is not allowed to apply a particular financial requirement *only* to MH/SUD benefits. So, for example, a health plan could not require only copayments for medical/surgical benefits and impose coinsurance on MH/SUD benefits.

Some health plans used to have separate deductibles for medical/surgical benefits and mental health/substance use disorder benefits. This is no longer allowed. Now health plans may have only one combined deductible for all benefits.

Quantitative Treatment Limitations (QTLs)

In addition to prohibiting unequal financial requirements, the Federal Parity Law requires parity in treatment limitations. There are 2 kinds of treatment limitations under the Law: **quantitative treatment limitations (QTLs)** and **non-quantitative treatment limitations (NQTLs)**.

A *quantitative treatment limitation (QTL)* is a limitation on treatment that is expressed in numbers. Quantitative treatment limitations include annual, episode (of illness or injury), and lifetime day and visit limits. Some examples are:

Deductible—the total amount you must pay for medical treatment before your health plan will start covering the cost of medical care for you and/or your dependents.

Copayment—a fixed dollar amount that you must pay each time you obtain a particular type of medical service, such as office visits or prescription drugs.

Coinsurance—a percentage of your medical care costs that you are required to pay for a particular type of care.

Out-of-pocket maximum—the total amount you will pay for medical care including your coinsurance and deductible amounts, but not premiums and usually not copayments. Once your out-of-pocket maximum is reached, your health plan pays for all of your covered medical expenses.

Substantially all means more than **2/3** of all plan payments for medical/surgical benefits in the category expected to be paid for the year.

If a financial requirement or QTL applies to less than 2/3 of medical/surgical benefits in a category, measured by plan payments, the plan cannot apply that financial requirement or QTL to mental health or substance use disorder benefits in that category.

Predominant means that the financial requirement/QTL is applied to more than **50 percent** of all plan payments for medical/surgical benefits in the category expected to be paid for the year.

This analysis can be complicated. For help, you may want to contact a benefits advisor at the Department of Labor/Employee Benefits Security Administration using the online tool askebsa.dol.gov or by phone at (617) 565-9600 (Boston regional office).

- The number of outpatient visits covered by a plan
- The number of inpatient days covered by a plan
- The number of treatments covered by a plan
- The frequency of visits/treatments allowed by a plan

For example, a health plan that allowed patients to have unlimited appointments per year with medical and surgical specialists but limited patients to only 5 appointments annually with a psychiatrist would be in violation of the Federal Parity Law.

Substantially All and Predominant Test to Determine Compliance with Parity

A health plan may not impose a financial requirement or a quantitative treatment limitation (QTL) on MH/SUD benefits within a category unless the same financial requirement or QTL:

- applies to **substantially all** medical/surgical benefits in the same category; and
- is no more restrictive than the **predominant** financial requirement or QTL applied to medical/surgical benefits in the category.

Cumulative lifetime or annual dollar limits, financial requirements and QTLs

The ACA prohibits cumulative lifetime or annual dollar limits for mental health and substance use disorder benefits that are considered Essential Health Benefits.

- Cumulative financial requirements are used to determine whether or to what extent benefits are provided based on accumulated dollar amounts, such as deductibles and out-of-pocket maximums.
- Cumulative QTLs are used to determine whether or to what extent benefits are provided based on accumulated unit of service amounts, such as annual or lifetime day or visit limits.

For private health plans, financial requirements and quantitative treatment limits may not accumulate separately for MH/SUD and medical/surgical benefits within a category. However, separate accumulation is permitted for Medicaid (MassHealth) MCOs as long as any financial requirement or QTL applied to MH/SUD benefits meets the **substantially all and predominant** test within a classification.

While a plan cannot cap visits or days covered for a mental health or substance use disorder benefit if it does not do so for medical/surgical benefits, the plan may “manage” its coverage of MH/SUD care in other ways. For example, the plan may evaluate mental health treatment after a certain number of sessions to determine if the treatment remains medically necessary. However, when a plan engages in this sort of **medical management**, it must comply with the Federal Parity Law’s rules on non-quantitative treatment limitations. (See next section on Non-Quantitative Treatment Limitations.)

Non-Quantitative Treatment Limitations (NQTLs)

Non-Quantitative Treatment Limitations (NQTLs) are plan standards that limit the scope and/or duration of benefits in ways that are not expressed in numbers. Some examples of NQTLs are:

- Medical management standards that limit or **exclude** benefits based on medical necessity (for example, a plan's policies on **prior authorization**)
- “Fail first” policies or step therapy protocols
- Conditioning benefits on completion of a course of treatment
- Network tier design
- Prescription drug **formulary** design
- Standards for health care providers to participate in a health plan's network, including but not limited to reimbursement rates
- Methods for determining providers' usual, customary, and reasonable charges
- Coverage limits based on geographic location, type of facility, provider specialty or other criteria that limit the scope or duration of coverage

These are examples and do not cover all possible NQTLs subject to the Federal Parity Law. The inclusion of NQTLs as a measure of parity is a critical aspect of the Federal Parity Law's protections because nearly all health plans rely on managed care methods to restrict care and limit costs.

NQTL Test for Parity Violation

Figuring out whether a NQTL violates the Federal Parity Law requires looking at the **processes, strategies, evidentiary standards, and other factors** the health plan uses to limit the scope or duration of MH/SUD benefits and medical/surgical benefits within a classification or category.

- The **processes, strategies, evidentiary standards, or other factors** applied to the MH/SUD benefit must be
 - **comparable to** and
 - **applied no more stringently than**
- The **processes, strategies, evidentiary standards, or other factors** used for medical/surgical benefits in the same category.

** A plan is not allowed to use a NQTL that is designed for the purpose of restricting access to MH/SUD benefits.*

The test for NQTLs does not require a mathematical calculation. Analysis of a NQTL under the Federal Parity Law should not focus on results but rather should look at the *processes* and *strategies* the health plan uses in applying the NQTL. Are there arbitrary or discriminatory differences in how the plan is applying those processes and strategies to medical/surgical benefits versus mental health and substance use disorder benefits? If the answer is yes, there may be a violation of the Federal Parity Law. Here are some examples involving pre-authorization of benefits:

NON-VIOLATION

A plan may be complying with the Federal Parity law even though the factors applied to MH/SUD and medical/surgical benefits in a category lead to different outcomes. For example:

- A health plan sets pre-authorization criteria for *all* inpatient in-network services based on the same 3 factors (pre-authorization is the NQTL)

As long as the 3 factors are applied consistently and no more stringently there is **no violation** even though application of the factors leads to more **denials** of MH/SUD care than medical/surgical care within the inpatient, in-network category.

VIOLATION

A health plan requires pre-authorization for all inpatient, in-network services.

- The plan routinely approves benefits for medical/surgical conditions for 7 days before the health care facility must submit a treatment plan.
- The plan routinely approves benefits for MH/SUD conditions only for 1 day before the health care facility must submit a treatment plan.

There is a Federal Parity Law violation because the NQTL (pre-authorization) is applied more stringently to MH/SUD services than to medical/surgical services within the inpatient, in-network category.

Scope of Service

The scope of service means the types of treatment and treatment settings that are covered by a group health plan or health insurance policy. The categories and sub-categories allowed under the law (inpatient in-network, outpatient in-network, etc.) are intended to cover the complete range of medical/surgical benefits and MH/SUD benefits offered by health plans and health insurance issuers.

Intermediate services are services that do not neatly fit into the inpatient or outpatient categories. Examples of MH/SUD intermediate services include residential treatment, partial hospitalization and intensive outpatient programs. On the medical/surgical side, intermediate services include rehabilitation hospitals, physical therapy and cardiac rehabilitation.

Intermediate services are subject to the Federal Parity Law. A health plan must assign covered intermediate services for MH/SUD and medical/surgical conditions consistently to one of the six classifications or categories, then apply the general parity test.

Thus, if a health plan covers a range of services and settings for medical and surgical conditions, it must cover a comparable range of services for mental health and substance use disorders. For example, if a health plan covers care in a skilled nursing or rehabilitation facility for medical and surgical conditions, the plan must cover residential or similar inpatient rehabilitative care for mental health and substance use disorders. A health plan or insurance company that excludes certain types of treatments and settings for MH/SUDs while permitting coverage of similar types of treatments and settings for medical/surgical conditions would violate the Federal Parity Law.

There is nothing in Federal Parity Law or the Final Rules under the Law that specifies the mental health and substance use disorder services that a health plan must cover within each benefit classification. However, the Final Rules provide guidance on the types of services to be provided based on the requirement of comparability between the medical/surgical and MH/SUD benefits in a plan.

Getting information to show a parity violation

The Federal Parity Law requires greater access for health plan members to information about how their health plan decides whether to pay for mental health and substance use disorder benefits. Access to more information will help plan members and their providers identify and challenge parity violations.

Health plans are expected to document how they apply financial requirements and treatment limitations to medical/surgical benefits and MH/SUD benefits. Health plan members and their providers may request information that may show whether a plan is discriminating in its coverage of mental health conditions and substance use disorders. The request should be made in writing. The plan must provide responsive information *free of charge*, generally within 30 days from receipt of the request.

A health plan subject to the Federal Parity Law must provide a member or participating provider:

- The **reason for the denial** of coverage for MH/SUD services;
- The **criteria** used for medical necessity determinations for MH/SUD benefits; and
- **Information required for a parity analysis:** *Upon request* a private health plan must release information to show whether the plan is complying with the Federal Parity Law, for example:
 - For a claimed QTL violation, a demonstration showing that the plan meets the predominant/substantially all test;
 - A description of a NQTL (e.g., prior authorization) that the plan has authorized for specified MH/SUD benefits;
 - Information regarding factors (e.g., cost) that a plan relies on to determine which benefits are subject to a specific NQTL;
 - A description of the NQTL used in denying coverage of a specific MH/SUD service;
 - Medical necessity guidelines relied upon by a plan for medical/surgical and MH/SUD benefits within a category (e.g., inpatient, in-network).

A group health plan must ensure that its insurance carrier (if fully insured) or third party administrator (if self-insured) is responding appropriately to member and provider requests for information required by the Federal Parity Law. A plan that uses a vendor or “carve-out” to manage mental health and substance use disorder benefits is still responsible for ensuring that benefits satisfy the Federal Parity Law. Medicaid (MassHealth) MCOs must provide members and potential members with medical necessity guidelines for MH/SUD and medical/surgical benefits upon request; Medicaid (MassHealth) MCOs must provide the other information above to the state.

IMPORTANT

Plan members and contracting providers may request information to determine whether a plan is complying with the Federal Parity Law even when there is no **adverse benefit determination** or appeal.

[A Consumer Guide to Disclosure Rights](#) can be found on the Department of Labor/Employee Benefits Security Administration (DOL/EBSA) website at:

<https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity> (click *For Workers and Families*, then *Publications and Video*, then *Disclosure Guide*)

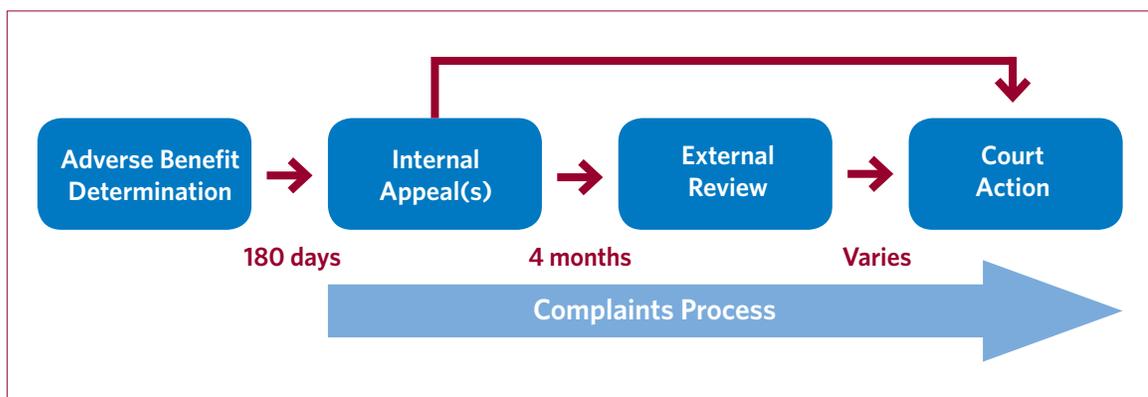
A NOTE ON MEDICAL NECESSITY

In general a health plan will not pay for services it does not consider *medically necessary*. Most plans define medical necessity in the benefit handbook, **evidence of coverage** or similar document. Fully insured health plans in Massachusetts must use the state medical necessity standard (see *Glossary*) while self-insured plans can use their own standards. A violation of the Federal Parity Law may involve medical necessity. For example, if a health plan requires that a member fail at outpatient substance use disorder treatment before qualifying for residential treatment, the plan violates parity if similar medical necessity criteria are not used for medical and surgical treatment settings.

HOW TO ASSERT PARITY RIGHTS

If a parity violation results in denial of mental health and substance use disorder benefits (referred to as an “adverse benefit determination”) for which a health plan member believes s/he qualifies, as a general rule the member must use the appeal process to assert his/her rights. An adverse benefit determination, which can be appealed, includes:

- Denial of benefits on the basis of lack of medical necessity
- Denial of benefits on the basis that a treatment is experimental or investigational
- Denial of benefits based on a claim that the service is excluded by the contract
- Reduction, termination or modification of benefits



Step 1: Adverse Benefit Determinations

An Adverse Benefit Determination must:

- Provide information sufficient to identify the claim
- Explain the reason(s) for the denial of benefits
- If based on medical necessity, include the criteria or explain how to get a copy
- Describe the appeal procedures available to the member

Step 2: Internal appeals

A health plan member must file an internal appeal before s/he can pursue an external appeal or court action. For a standard (non-expedited) appeal the member has **180 days** to appeal from the date s/he receives the adverse benefit determination.

- The plan must issue a written decision on the appeal within 30 days of receiving the appeal. (In Massachusetts a fully insured plan that fails to decide the appeal on time must approve the member's request for benefits.)

In some cases a member has the right to an **urgent** or **expedited appeal**

- For fully insured health plans in Massachusetts expedited appeal is available when, in the treating health care provider's opinion:
 - the service is medically necessary;
 - a denial of coverage would create a substantial risk of serious harm to the member; and
 - the risk of serious harm is so immediate that treatment should not have to wait 30 days

Similar standards apply to appeals to self-insured plans.

A health plan must decide an urgent or expedited appeal within 72 hours of receiving the appeal. The member is permitted to file a request for **external review** (see Step 3 below) at the same time as the urgent/expedited internal appeal.

Information to get from the plan

Some health plans contract with another company to manage mental health and substance use disorder benefits. This is sometimes referred to as a "carve-out." You are entitled to information about your plan and your claim regardless of who manages the benefit.

You have the right to request and receive from your health plan:

- The complete **claim file** which may include, among other documents
 - Medical records
 - Plan medical necessity and/or level of care guidelines
 - Internal plan notes (e.g., member service phone log)
 - Copies of adverse determinations
- Any relevant documents not included in the claim file including, for example
 - **Explanations of Benefits (EOBs)**
 - Summary Plan Description (SPD)*
 - Other documents regarding the operation of the Plan*
- If you are claiming a parity violation, comparative information about the Plan's treatment of medical/surgical benefits

*Some documents concerning the operation of an employer-sponsored health plan are the employer's responsibility and may need to be requested through the employer's Human Resources department.

Information to submit in an appeal

- An appeal letter making the case for why benefits should be approved. **The appeal letter should reflect the member's specific treatment needs as documented by medical records and letters of support from treating health care providers.**
- A response to any new reason for denial that the Plan has given (additional time must be allowed for this response)
- Bills from the health care provider or facility showing the cost of the services
- Letters of support from health care providers
- Articles from respected medical journals, especially if the appeal is for treatment the Plan considers "experimental" or "investigational"

COVERAGE OF ONGOING TREATMENT PENDING DECISION ON APPEAL

You may have the right to coverage of disputed treatment while the **internal appeal** is reviewed. In general, benefits for ongoing treatment cannot be reduced or terminated without advance notice and an opportunity for advance review. In certain cases, this means that a member who appeals the termination or reduction of ongoing treatment is eligible to continue receiving the treatment at the health plan's expense until the internal appeal decision is issued.

Step 3: External Review and Court Action

External review is available only in the following 3 types of cases:

- 1) cases involving determination of medical necessity or the exercise of medical judgment
- 2) a claimed violation of a non-quantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits
- 3) a rescission of coverage (retroactive cancellation)

External reviews are conducted by **Independent Review Organizations (IROs)**, also referred to in Massachusetts as External Review Agencies (ERAs).

Regardless of the kind of plan, fully insured or self-insured, private employer or non-federal government employer, a request for external review must be filed within **4 months** from the final health plan denial (final adverse determination).

External review is voluntary. A member can skip this step and go straight to court. In some cases a plan member may go through external review and then proceed to court. **A decision as to whether to pursue external review and/or bring a court action should be made in advance in consultation with a qualified attorney.** For consumers enrolled in a fully-insured non-group health plan, external review decisions are binding on the insured and on the insurance company. Going through the external review process may prevent you from taking your case to court or may limit the relief you can get if you do go to court.

The limitation on the right to bring a court action does not apply to consumers with health insurance through a private employer. These consumers have additional rights under a federal law called the **Employee Retirement Income Security Act (ERISA)**. However, filing and losing an external review may affect how a judge decides a case you bring in court. If you are considering court action, consult an attorney promptly and be aware of any deadlines stated in your insurance plan or set by law.

The kind of plan you have affects where to file a request for external review. Massachusetts residents with fully insured plans that opt for external review must file external review requests with the **Office of Patient Protection (OPP)**.

A self-insured private employer health plan must have an external review process (unless the plan is grandfathered), under which the plan contracts with at least 3 IROs for external appeals.

Self-insured **non-federal government health plans** may either contract directly with IROs or use the external review process managed by the federal Department of Health and Human Services (HHS).

The timelines for federal external review procedures are the same as for appeals through the Office of Patient Protection; you have **4 months** from receiving the health plan's final adverse determination to request external review. Other requirements are also similar to those that apply in OPP-eligible cases.

Grandfathered health plans are exempt from external review requirements, but some grandfathered plans offer a voluntary final review, after completion of internal appeals, by a designated person or panel, such as a union board of trustees.

Health Policy Commission Office of Patient Protection

50 Milk Street, 8th Floor
Boston, MA 02109

Phone: 1-800-436-7757

Fax: 1-617-624-5046

Email: **HPC-OPP@
state.ma.us**

Web: **www.mass.gov/
hpc/opp**

PURSUING APPEAL: BEST PRACTICES

- Understand the terms of your health insurance policy
- Request the claim file
- Request documents to figure out parity compliance (if claiming a parity violation)
- Obtain medical documents from your health care provider(s)
- Get letter(s) of support from provider(s)
- Write appeal
- Pay attention to deadlines

HOW AND WHERE TO COMPLAIN TO ENFORCEMENT AGENCIES

It is important to let the government know if you think your or a family member's parity rights have been violated. But remember—a complaint to a federal or state agency charged with enforcing the mental health parity laws does not take the place of filing an appeal with your health plan. **If you believe you have been denied medically necessary care that should be covered by your plan you must appeal *within the required time to preserve your rights*.**

You can file a complaint with state and/or federal regulators at the same time or wait until you have completed your appeal. Even if you win your appeal you should report suspected violations of the parity laws. You will help ensure that health insurance plans follow the rules and provide the coverage they should for everyone.

Reporting violations of the Federal Parity Law

State and federal agencies share authority for enforcing the parity laws. Once you determine the kind of health plan you have—fully-insured or self-insured, private employer, state or local government employer, Medicaid (MassHealth)—you can find below, and in the table on **page 19**, which agency or agencies can best handle your complaint of a mental health parity violation.

Massachusetts Division of Insurance

If you have a fully insured plan, whether individual, through a private employer or through a non-Federal governmental employer in Massachusetts, file your mental health parity complaint with the Division of Insurance (DOI). Here is a link to the DOI's complaint form www.mass.gov/ocabr/docs/doi/consumer/css-complaint-form.pdf.

You can also call the Division's Consumer Services Section at 877-563-4467 or 617-521-7794. All complaints made by telephone must be followed by a written complaint to the Consumer Services Section, which must include the following information:

- your name and address;
- the nature of your complaint; and
- your signature authorizing the release of necessary information to the Division.

Office of the Massachusetts Attorney General, Health Care Division

The Health Care Division within the Massachusetts Attorney General's Office accepts complaints involving private, fully-insured health plans, including mental health parity complaints.

Learn more about the Attorney General's Complaint process at www.mass.gov/ago/consumer-resources/consumer-assistance/health-care-complaint.html.

Fill out an electronic complaint at www.eform.ago.state.ma.us/ago_eforms/forms/hcd_eomplaint.action or fax your complaint to 617-573-5386.

- If your complaint is urgent or if you seek an accommodation due to a disability, please call the Health Care Helpline at 888-830-6277 or 617-727-4765 TTY.

Mail complaints to: Health Care Division, Office of the Attorney General, One Ashburton Place, Boston, MA 02108

Department of Labor/ Employee Benefits Security Administration (DOL/ EBSA)

The DOL/EBSA handles mental health parity complaints involving self-insured private employer health plans. Complaints can be filed by phone, in writing or by email. For assistance, call 866-444-3272 or visit www.askebsa.dol.gov for information. Helpful information to include in a written complaint includes:

- Your name and daytime telephone number
- A brief explanation of the problem
- Evidence that you have filed a claim for benefits
- Name, address and telephone number of your employer or health plan official
- Your permission for DOL/EBSA to inquire on your behalf
- Employment dates, birth date, policy number or other identifying information

Department of Health and Human Services/Centers for Medicare and Medicaid Services (HHS/CMS)

The Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services (HHS) handles mental health parity complaints involving non-federal governmental employer plans (state and local) that are **self-insured**. (An example of such a plan is the UniCare Indemnity Plan offered to Massachusetts state employees by the Group Insurance Commission.) Complaints can be filed by phone with the CMS Health Insurance Helpline at 877-267-2323 x 6-1565 or by email to phig@cms.hhs.gov or NonFed@cms.hhs.gov.

MassHealth

The state Executive Office of Health and Human Services (EOHHS) and the Office of Medicaid enforce federal parity requirements that apply to MassHealth plans. The Federal Parity Law only covers Medicaid Managed Care Organizations (MCOs), CarePlus Plans and the Children's Health Insurance Program (CHIP/Family Assistance). If you have a complaint of a parity violation you can contact your MCO and/or MassHealth. You can submit your complaint by phone or in writing. Please contact MassHealth Customer Service at 800-841-2900 or review your member handbook to review the ways your particular plan accepts parity complaints.

AGENCIES RESPONSIBLE FOR ENFORCING PARITY LAWS			
Massachusetts State Agencies			
State Agency	Division of Insurance	Office of Medicaid (MassHealth)	Attorney General's Office
Plan type(s)	Fully-insured MA health plans (large group, small group, and individual)	MassHealth Managed Care Organization (MCO) plans; CarePlus plans	Fully-insured MA health plans
Phone complaint?	877-563-4467	MassHealth Customer Service: 800-841-2900	AG Health Care Hotline: 888-830-6277
Written complaint?	Required	Yes or verbal	Yes; e-complaint or mail complaint
More info:	Complaint form online: www.mass.gov/doi	Call MassHealth or your MCO's customer service for more information	Complaint form online: www.mass.gov/ago
Federal Agencies			
Federal Agency	Department of Labor / EBSA	Department of Health & Human Services/ CMS	
Plan type(s)	Employer-sponsored large group plans	Non-federal government employee plans (e.g. GIC)	
Phone complaint?	866-444-3272	877- 267-2323 x 6-1565	
Written complaint?	E-complaint process	Yes; mail or e-mail (phig@cms.hhs.gov or NonFed@cms.hhs.gov)	
More info:	www.askebsa.dol.gov		

APPENDIX A: Glossary

Adverse benefit determination—a decision by your insurance company to deny or reduce payment for a particular medical service, or to terminate your health insurance coverage.

Affordable Care Act—the national health care reform law signed by President Obama in 2010.

Children's Health Insurance Program (CHIP)—An insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid (MassHealth) but not enough to buy private insurance.

Claim file—all of the information and documents involved in an insurer's review of a requested treatment or service, which should be provided at no cost to you.

Classification—a grouping or category of benefits in a health plan subject to the Federal Parity Law: inpatient (in-network and out-of-network); outpatient (in-network and out-of-network); emergency care; prescription drugs. For Medicaid plans the Federal Parity Law does not distinguish between in-network and out-of-network).

Coinsurance—a percentage of your medical care costs that you are required to pay under your health plan for a particular type of care.

Coordination of Benefits (COB)—when an individual is covered by two or more insurance plans, COB rules determine how much of a treatment or service each plan covers.

Copayment (or Copay)—a fixed dollar amount that you must pay each time you obtain a particular type of medical service, such as office visits or prescription drugs.

Deductible—the total amount you must pay for medical treatment before your health plan will start covering the cost of your medical care for you and/or your dependents.

Denial—a decision by an insurance company not to pay for treatment either before it is delivered or after you have received it.

Eligibility—whether a person has the right to enroll in a given health plan.

Employee Retirement Income Security Act (ERISA)—a federal law that sets minimum standards for health and other benefit plans established by private employers for their eligible employees.

Essential Health Benefits (EHB)—Benefits that must be covered by plans sold on the health insurance Exchange or Marketplace (in Massachusetts, the Health Connector) and by all individual and most small group plans sold outside the Exchange.

Evidence of Coverage (EOC)—a lengthy document describing in detail your benefits and rights under the plan; may also be called a Subscriber Certificate, Benefit Handbook or other similar title.

Exclusion—a service or treatment that is not covered by your plan.

Explanation of Benefits (EOB)—a notice the insurance company sends after processing a claim which includes the provider name, the date of service, the payment level or allowed amount, the amount covered, and what the patient has to pay (for example, a copayment, coinsurance or deductible).

External review—an appeal that is sent to an independent review organization for a decision.

Federal Employees Health Benefit (FEHB) Program—A health insurance program for federal government employees, other than military personnel, and their families.

Federal Parity Law—the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; also referred to as MHPAEA.

Financial requirement—under the Federal Parity Law, costs for which a health plan member is responsible, including deductibles, coinsurance, copayments, and out-of-pocket maximums.

Formulary—the list of prescription drugs that are covered by a health plan.

Fully insured plan—a health plan in which the insurance carrier bears the financial responsibility for paying benefits under the terms of the plan. A fully insured plan may be an individual plan or a group plan offered through an employer.

Grandfathered plan—a health plan that was in effect on March 23, 2010 and which has not changed substantially since that date.

Group health plan—health insurance that is offered to a group of people, most commonly employees of a company or organization.

Group Insurance Commission (GIC)—an entity established by state law to provide and administer health insurance and other benefits to employees and retirees of the Commonwealth of Massachusetts, housing and redevelopment authority personnel, participating municipalities, and certain retired municipal employees and teachers.

Independent Review Organization (IRO)—an entity that reviews a health plan's final decision not to cover a service. Also referred to in Massachusetts as an External Review Agency or ERA.

Individual (non-group) plan—a health insurance plan that is not sponsored by an employer or the government, which can be purchased on the state Exchange or Marketplace (the Health Connector in Massachusetts) or directly from an insurance company.

Internal appeal—an appeal from a denial of medical benefits that is submitted to and reviewed by your health plan.

Massachusetts Mental Health Parity Law—a law that mandates specified coverage for mental health conditions and substance use disorders in health insurance policies issued or renewed by Massachusetts-licensed insurance companies and Group Insurance Commission plans for state and municipal employees and retirees.

MassHealth—Massachusetts' Medicaid program, which is funded jointly by the federal government and Massachusetts, and operated by the state Executive Office of Health and Human Services.

Medically necessary—a standard used by an insurance company to determine whether treatment or services are appropriate for a specific patient. Under Massachusetts state law, fully insured health plans must use the following standard:

Medical Necessity or Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service: (a) is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

In addition to a general definition similar to the above, most health plans use detailed medical necessity guidelines to decide on coverage of specific services.

Network—the group of doctors, hospitals, and other health care providers with which a health plan contracts to provide its members with health care services.

Non-federal government plan—a health plan sponsored by a state or local government unit for its employees and their family members; for example, health insurance plans offered by the Group Insurance Commission (GIC).

Non-quantitative treatment limitation (NQTL)—standards not expressed in numbers that are used by a health plan to determine whether the plan will pay for health care services, for example, medical necessity criteria and prior authorization of benefits.

Out-of-Network Provider—a medical provider (such as a doctor or hospital) that has not contracted with your insurance plan to provide medical services at a negotiated rate. A patient who uses an out-of-network provider is generally responsible for higher charges.

Out-of-pocket maximum—the total amount you will pay for medical care, including your coinsurance and deductible amounts, but not premiums and usually not copayments. Once your out-of-pocket maximum is reached, your health plan pays for all of your covered medical expenses.

Prior authorization—a request by your provider to have coverage of a particular service or treatment authorized in advance by your health plan.

Provider—a doctor, other medical professional or health care facility that delivers health services.

Quantitative treatment limitation (QTL)—treatment limitations expressed in numbers, other than financial requirements, used by a health plan (such as a limit on outpatient visits per year).

Self-insured plan—a health plan in which the employer, not an insurance company, is responsible for the cost of health benefits provided to employees. Also referred to as a **self-funded plan**.

Small Group Health Plan—a health plan covering employees of a business with 1 to 50 employees.

Summary Plan Description (SPD)—the Summary Plan Description (SPD) communicates important information about an ERISA group health plan to plan members and must be provided by the health plan administrator in response to a member's written request.

Tiered health plan—a health plan that contracts with a network of health care providers, subgroups of which are assigned to different levels (tiers) requiring different costs for members.

TRICARE—a health care program for active-duty and retired uniformed services members and their families.

Urgent appeal—an **expedited** appeal based on evidence that delaying medical care would place the patient's life or health in jeopardy.

APPENDIX B: Appeal Letter Template

[Your Name]
[Address]
[Phone Number]

Sent by Certified Mail
Return Receipt Requested

[Date]

[For internal review, Insurer or Health Plan Name/Address]

[For external review, Office of Patient Protection or addressee indicated for self-insured plan]

Patient/Member Name:

Subscriber Name (if different):

ID#:

Group (if through an employer or group):

Plan:

Provider:

Treatment:

Treatment Date:

To Whom It May Concern:

I am appealing the denial of [name of treatment] dated [date of denial] for service provided/requested on [date of service or authorization submission].

According to the denial letter, this treatment has been denied because [include the language/reasons from the denial notice]. I have included a copy of the denial letter.

I believe this denial should be overturned for the following reasons [if denial is based on medical necessity list each of the reasons you meet the criteria, including, e.g., your medical needs, prior unsuccessful treatments, expected result, etc.] [if denial is based on reason other than medical necessity discuss why the insurer/plan's decision is wrong].

If applicable: I believe that NAME OF HEALTH PLAN has violated the [state/Federal/both] mental health parity law(s) when it denied coverage for [describe service]. The specific basis for my claim of a parity violation is [provide details—for example, the plan required prior authorization for my outpatient substance use treatment, but it does not require prior authorization for outpatient treatment of medical or surgical conditions].

I have enclosed a letter of support from my doctor that states [summarize the information in the doctor's letter].

I have included the following medical records [list the copies of documents (not originals) you are including], which support my appeal.

I have included a personal statement [if applicable, briefly summarize].

For the reasons outlined above, I request that the denial be reversed. Please do not hesitate to call me if you require additional information or have any questions.

Sincerely,

Your Name

Enclosures

APPENDIX C: Sample Letter Requesting Information from Plan

ABC Health Plan

Attention: Claim Records Dept. [or addressee provided in denial letter]

ADDRESS

RE: MEMBER NAME (DOB xx/xx/20xx)

Health Plan ID #/NAME OF PLAN

Request for documents re ABC Health Plan Denial

To Whom It May Concern:

In a letter dated xx/xx/20xx, ABC Health Plan issued an adverse determination with respect to [my or MEMBER NAME's] treatment at FACILITY OR PROVIDER. [Attach copy of adverse determination letter.] [I or MEMBER NAME] intend[s] to file an appeal by the deadline. THIS LETTER DOES NOT CONSTITUTE THE APPEAL.

[I or MEMBER NAME] request[s] copies of [my or his/her] claim file and all other documents relevant to the claim and adverse determination, including but not limited to:

- a) The reason for the denial of coverage of the requested treatment;
- b) any rule, benefit provision, guideline, criteria or protocol used in making the adverse determination;
- c) billing and service code information; and
- d) communications within ABC Health Plan and between the Plan and others, regarding [my or MEMBER NAME's] coverage or treatment

This request covers all documents, records and information submitted, considered, or generated in the course of the benefit determination, *without regard to* whether such documents, records or information were relied upon in making the benefit determination. See 29 CFR § 2560.503-1(m)(8).

[I or MEMBER NAME] further request[s], pursuant to 29 CFR § 2590.712(d)(3), disclosure of all information relevant to medical/surgical, mental health, and substance use disorder benefits for purposes of evaluating ABC Health Plan's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) in the handling of [my or MEMBER NAME's] claim. This request includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, and the processes, strategies, evidentiary standards, and other factors used by ABC Health Plan to apply any non-quantitative treatment limitations (NQTLs) with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

To afford a full and fair review of [my or MEMBER NAME's] claim, as required by law, please send all of the requested documents via mail within 30 days of the Plan's receipt of this request. [OPTIONAL—If I do not received the requested documents within the time specified, I intend to file a complaint with the appropriate state and/or federal authorities.] Please contact me by phone (xxx-xxx-xxxx) or email (ADDRESS) if you have any questions about this request.

Sincerely yours,

Enclosures: [Copy of adverse determination]

cc: PROVIDER NAME

APPENDIX D: Sample Authorization to Health Care Provider or Health Plan to Release Protected Health Information

Authorization for Release of Protected Health Information

I, _____, of _____, Massachusetts, authorize the below-identified Provider or Health Plan to disclose in writing my protected health information. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may no longer be protected under federal or state law.

1. I authorize the following Provider or Health Plan to disclose my protected health information:

Organization:

Staff Name:

Address:

2. I authorize the Provider or Health Plan to release in writing my protected health information to:

Organization:

[Insert Name of Organization]

Name of Contact:

[Insert Name of Contact]

Address:

3. Specific description of the protected health information that I authorize for use or disclosure (authorization to disclose psychotherapy notes must be separate):

- I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and the treatment of alcohol/drug abuse)

OR

- I hereby authorize the release of my complete health record with the exception of the following information:
 - Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Other (please specify) _____

4. Specific description of the purpose for each use or disclosure (or write "At my request"):

5. I understand that I may revoke this authorization at any time by sending a signed and dated letter to the Provider or Health Plan, except to the extent that the Provider or Health Plan has already acted in reliance on this authorization.

6. This authorization expires on _____.

I have read and understand this authorization. I confirm that the contents are consistent with my direction. I confirm that the below is my signature and that I am legally authorized to sign.

Signed _____ Date _____

Name: _____

Address: _____

Date of birth: _____

Relationship or Authority of Personal Representative: _____

(Please attach documentation of legal authority to act on behalf of the named individual.)

**This form is based on a template created and used by Health Law Advocates. Health plans and health care providers often have their own forms for this purpose.*

APPENDIX E: RESOURCES

For [Legal Help](#) in Massachusetts with health plan appeals and parity violations:

- **Health Law Advocates (HLA)** is a Massachusetts based public interest, non-profit law firm that helps low-income consumers across the state with legal issues related to their health care coverage. HLA assists people who have been denied health care coverage by their public or private insurance plan.
 - *Phone Number:* 617-338-5241, *Toll-Free Number:* 888-211-6168
 - *Website:* www.healthlawadvocates.org

Other Massachusetts Resources

- The **Bureau of Substance Abuse Services (BSAS)** oversees substance abuse prevention and treatment services in the Commonwealth.
 - *Website:* www.mass.gov/dph/bsas
 - *Phone Number:* 617-624-5111
 - *TTY and ASCII Users:* 800-720-3480
 - *Voice and Hearing Users:* 800-327-5050
 - *Confidential Complaint Lines Phone:* 617-624-5171
- The **Department of Mental Health (DMH)** provides and coordinates access to services and supports to meet the mental health needs of individuals found eligible for services. The Department sets state mental health policy and supports mental health training and research.
 - **Resource Guides** — The Department of Mental Health publishes several resources guides that help consumers, families and the general public find information about DMH services and other mental health services and programs statewide.
 - *Webpage:* www.mass.gov/eohhs/provider/guidelines-resources/clinical-treatment/mental-health/dmh-resource-guides.html
 - *Information and Resource Line:* 800-221-0053
- **Health Care for All (HCFAMA)** is a nonprofit advocacy organization working to create a health care system that provides comprehensive, affordable, accessible, and culturally competent care to all Massachusetts residents, through leadership in public policy, advocacy, education and service.
 - *Website:* www.hcfama.org
 - *Phone Number:* 617-350-7279
 - **Health Care For All Helpline** is available to answer questions about health insurance in Massachusetts. The HelpLine is staffed by specially-trained counselors with up-to-date information about health care coverage. *Helpline Phone Number:* 800-272-4232, 9:00 am–5:00 pm, Monday–Friday.

- **Learn2Cope** is a non-profit support network that offers education, resources, peer support and hope for parents and family members coping with a loved one addicted to drugs. The organization has over 7000 members and is a nationally recognized model for peer support and prevention programming.
 - *Website:* learn2cope.org
 - *Phone Number:* 508-738-5148
- The **Massachusetts Organization for Addiction Recovery (MOAR)** is a non-profit organization whose mission is to organize recovering individuals and their families, and friends into a collective voice to educate the public about the value of recovery from alcohol and other addictions.
 - *Website:* www.moar-recovery.org
 - *Phone Number:* 617-423-6627 or toll-free, 877-423-6627
- The **National Alliance on Mental Illness of Massachusetts (NAMI Mass)** is a nonprofit grassroots education, support and advocacy organization with 18 local affiliates and over 2,500 members comprised of individuals with mental illness, family members and others in the mental health community.
 - **NAMI Compass Project** is operated by peers and family members who have dealt with mental illness first hand. Navigators can answer a wide range of questions and refer to NAMI support and education programs as well as other community resources.
 - *Website:* namimass.org/resources/compass
 - *Phone Number:* 617-704-NAMI (6264) or toll free, 800-370-9085, 9:00 am–5:00 pm, Monday–Friday

Select National Resources

- **Community Catalyst** is a national non-profit advocacy organization working to build consumer and community leadership to transform the American health system.
 - *Main Website:* www.communitycatalyst.org
 - *Substance Use Disorders Website:* www.communitycatalyst.org/initiatives-and-issues/initiatives/substance-use-disorders
- **Department of Labor Website on Mental Health Parity**
 - *Website:* www.dol.gov/ebsa/mentalhealthparity
- The **Parity Implementation Coalition** worked for passage of the Mental Health Parity and Addiction Equity Act of 2008 and continues to support and advance the Federal Parity Law's full implementation and enforcement.
 - *Website:* parityispersonal.org

- **The Kennedy Forum** was founded in 2013 to convene cutting-edge thinkers united by the potential for reform in mental health service delivery made possible by new laws, new technologies and an enhanced understanding of effective services and treatments.
 - *Website:* www.thekennedyforum.org
- **Parity Track** aims to be the comprehensive resource for information about mental health and **substance use disorder** parity. This internet-based tool seeks to help consumers understand and enforce their rights under **Federal** and **State parity laws**.
 - *Website:* www.paritytrack.org