New York State Attorney General Letitia James

Dear New Yorkers:

If you have been denied health plan coverage for mental health or addiction treatment, or you or a loved one are considering seeking such treatment, make sure that you are aware of the New York State and federal mental health parity laws. These laws protect consumers by requiring health plans to provide coverage for mental ailments that is comparable to coverage for physical ailments.

Mental health and addiction recovery treatments must be regarded the same as other health insurance claims under the law. My office has taken an aggressive approach to enforcing these laws and will continue to take on those who ignore the law and, by doing so, reinforce the false and painful stigma often associated with behavioral health conditions. If you believe that your health plan may be in violation of these laws, you should contact the Attorney General's Health Care Bureau.

Sincerely,

Letitia James

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New York State Attorney General
The State Capitol
Albany, New York 12224
1-800-771-7755
Health Care Bureau Consumer Helpline: 800-428-9071
www.ag.ny.gov

TIPS

- Take the time to understand what the mental health parity laws require, and review your health plan's benefits carefully.
- Make sure that your provider has your health plan's medical necessity criteria and supplies information about your care to the plan as requested.
- Ask your health plan for information about any denials you receive, and appeal those denials, or ask your provider to do so on your behalf.

RESOURCES

Office of the Attorney General
Health Care Bureau
Consumer Helpline: 800-428-9071
Complaint Form and Other Information:
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:
www.dfs.ny.gov/insurance/extapp/extappqa.htm

United States Department of Labor
Employee Benefits Security Administration
New York Regional Office
Telephone: 212-607-8600
Complaint Form:
www.askebsa.dol.gov/WebIntake/Home.aspx

Mental Health Parity Laws:

Ensuring Equal Access to Treatment Coverage

NEW YORK STATE OFFICE
of the
ATTORNEY GENERAL
Health Care Bureau

Mental Health Parity Laws

Both New York State and federal laws require that health plans provide a comparable level of benefits for mental health and substance use disorder (behavioral health) treatments as they do for medical and surgical care.

New York State

"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 at least 30 days of inpatient care and 20 visits of outpatient care per year.
- Conduct utilization review and calculate co-payments and co-insurance in a manner consistent with medical/surgical benefits.

New York group health plans also must provide coverage for:

- At least 60 outpatient visits per year to treat substance use disorder, up to 20 of which may be for family members.
- Inpatient substance use disorder treatment, including detoxification and rehabilitation.

Federal Laws

The Mental Health Parity and Addiction Equity Act and the Affordable Care Act require that the behavioral health coverage of most health plans be no more restrictive than medical/surgical coverage in 4 key areas:

- Annual and lifetime dollar limits on benefits.
- Financial requirements: deductibles, co-payments, co-insurance, and out-of-pocket expenses.
- Quantitative treatment limitations: limits on the frequency of treatment, number of days, visits, etc.
- Non-quantitative treatment limitations: including utilization review, provider network participation standards, out-of-network reimbursement amounts, and "fail first" requirements.

Does Your Health Plan Comply?

Look for differences between how the plan treats behavioral health services and medical services, including higher co-payments, separate deductibles for behavioral health, exclusion of coverage for services such as residential treatment, and different preauthorization requirements.

Other issues that should raise red flags include:

- "Fail first" requirements.
- Denials based on failure to complete treatment or plan's conclusion that consumer will not improve.
- Higher denial rates.
- Reduced payment for out-of-network provider.
- Insufficient or incorrect information in denial letters
- Refusing to provide medical necessity criteria or using criteria that do not match your condition.
- Failure to consult with your provider or consider medical evidence supplied.
- Refusal to reimburse treatment by a licensed mental health provider.
- No access to an in-network mental health provider who can see you in a reasonable amount of time at an accessible location.
- Lower day/visit limits.

Protecting Your Rights:

It's important to keep good records and follow your health plan's rules:

- Make sure your provider gets authorization from your health plan, if required.
- For each coverage request, make sure your provider has a copy of the health plan's medical necessity criteria and explains to the plan why you meet them, and submits medical records.
- For each contact with the health plan, ask for and note the name, title and ID number of the person, the date, time, and what the person said, and ask for written confirmation.

Coverage Denied?

Check the denial letter for accuracy and inform plan of mistakes. Also, ask your provider to submit a letter of medical necessity, including facts that show that you meet the relevant medical necessity criteria, point-by-point.

If possible, put requests for information in writing. The plan is required to provide you with the following, upon request:

- A written, detailed explanation of the denial.
- A comprehensive set of plan documents and your claim file, records and other information relevant to the claim.
- Documents comparing the plan's medical necessity criteria and utilization review processes for medical benefits and behavioral health benefits.
- Confirmation that the plan's criteria match the level of care that you seek, 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 your provider.

Appeals

Either you or your provider may appeal a denial, by phone or in writing.

Internal Appeals (decided by the plan):

- Expedited: for continued treatment or when your provider indicates 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: Your plan must continue coverage pending completion of internal appeals. New York plans for inpatient treatment for substance use disorder may not deny coverage while a decision is pending if an appeal is submitted at least 24 hours prior to discharge.

External Appeals (decided by a neutral expert):

- Generally available for medical necessity denials, experimental treatment exclusions, and out-of-network denials.
- Expedited: if your provider states that a delay in providing treatment would pose an imminent or serious threat to your health, the appeal must be decided within 72 hours.

NOTE: Do not enter into a "self pay" arrangement with your provider until after the appeals process has been completed.