Topic Four: Health Insurance 101 and Mental Health Parity

1. **When should a person file for an appeal?**
   If your health plan denies a claim, you have the right to appeal the denied claim by asking your health plan to look at its decision again, and perhaps reverse and pay the claim. Call your health plan and ask how to appeal a claim. If your health plan still denies your claim after you appeal, the Mississippi Insurance Department may be able to assist by filing an external appeal. Contact the Department at (601)359-3569 for more information.

2. **What should a person do to file an appeal?**
   To file an internal appeal, you need to:
   - Complete all forms required by your health insurer. Or you can write to your insurer with your name, claim number, and health insurance ID number.
   - Submit any additional information that you want the insurer to consider, such as a letter from the doctor.
   - The Consumer Assistance Program in your state can file an appeal for you. You can reach them at consumer@mid.ms.gov .
   - You must file your internal appeal within 180 days (6 months) of receiving notice that your claim was denied. If you have an urgent health situation, you can ask for an external review at the same time as your internal appeal.

   If your insurance company still denies your claim, you can file for an external review.

3. **What papers does a person need to file an appeal?**
   Keep copies of all information related to your claim and the denial. This includes information your insurance company provides to you and information you provide to your insurance company like:

   - The Explanation of Benefits forms or letters showing what payment or services were denied.
   - A copy of the request for an internal appeal that you sent to your insurance company.
   - Any documents with additional information you sent to the insurance company (like a letter or other information from your doctor).
   - A copy of any letter or form you're required to sign, if you choose to have your doctor or anyone else file an appeal for you.
   - Notes and dates from any phone conversations you have with your insurance company or your doctor that relate to your appeal. Include the day, time, name, and title of the person you talked to and details about the conversation.
   - Keep your original documents and submit copies to your insurance company. You'll need to send your insurance company the original request for an internal appeal and your request to have a third party (like your doctor) file your internal appeal for you. Make sure to you keep your own copies of these documents.

4. **What kinds of denials can be appealed?**
   You can file an internal appeal if your health plan won't provide or pay some or all of the cost for health care services you believe should be covered. The plan might issue a denial because:
   - The benefit isn't offered under your health plan
   - Your medical problem began before you joined the plan

- You received health services from a health provider or facility that isn't in your plan's approved network
- The requested service or treatment is "not medically necessary"
- The requested service or treatment is an "experimental" or "investigative" treatment
- You're no longer enrolled or eligible to be enrolled in the health plan
- It is revoking or canceling your coverage going back to the date you enrolled because the insurance company claims that you gave false or incomplete information when you applied for coverage

5. **How long does an internal appeal take?**
   Your internal appeal must be completed within 30 days if your appeal is for a service you haven't received yet.
   Your internal appeals must be completed within 60 days if your appeal is for a service you've already received.
   At the end of the internal appeals process, your insurance company must provide you with a written decision. If your insurance company still denies you the service or payment for a service, you can ask for an external review. The insurance company's final determination must tell you how to ask for an external review.

6. **What if a person's care is urgent and they need a faster decision?**
   In urgent situations, you can request an external review even if you haven't completed all of the health plan's internal appeals processes. You can file an expedited appeal if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. You may file an internal appeal and an external review request at the same time.

   A final decision about your appeal must come as quickly as your medical condition requires, and at least within 4 business days after your request is received. This final decision can be delivered verbally, but must be followed by a written notice within 48 hours.

Mental Health and Substance Abuse Disorder & Parity

1. **What is the Mental Health Parity and Addiction Equity Act?**
   The Mental Health Parity and Addiction Equity Act of 2008 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.

2. **What does Parity mean?**
   Parity here means that financial requirements, such as copayments, 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.

3. **What is an example of Parity?**
   If your plan appears to pay less for mental health and substance use disorder benefits for out-of-network medical/surgical benefits, you may have a parity issue. Your plan will determine the "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; a schedule of "usual, customary, and reasonable rates" developed by a third party; or the plan's own, proprietary fee schedule.

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 is equality of coverage?**
   If your plan covers some mental health or substance use disorder services, then that coverage must be essentially equal to coverage offered for similar medical services. This generally means that the limits that are applied to mental health or substance use disorder services can't be more restrictive than the limits applied to medical and surgical services.

6. **What is an example of unequal coverage?** Your plan covers an unlimited number of medical office visits each year, but behavioral health counseling is limited to 6 visits per year (meaning only 6 visits will be covered by your insurance). Coverage for behavioral health office visits may not be limited or capped because there is no similar limit or cap on visits for medical services.

7. **What are early warning signs of mental illness?**
   - Inability to perform daily tasks like taking care of your kids or getting to work or school
   - Pulling away from people and usual activities
   - Feeling unusually confused, forgetful, on edge, angry, upset, worried, or scared

8. **What is the prevalence of mental illness?**
   18.9% of adults in the U.S. have a mental, behavioral, or emotional disorder.

9. **What are the potential benefits of the Mental Health and Substance Abuse Disorder & Parity Act?**
   - 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.

10. **What are some examples of common limits placed on 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

11. What information are consumers entitled to receive from their 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.

"The information described was supported by Funding Opportunity Number PR-PRP-18-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies."