MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT RESOURCE GUIDE

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THE UNIVERSITY OF MARYLAND CAREY SCHOOL OF LAW
DRUG POLICY AND PUBLIC HEALTH STRATEGIES CLINIC

PARITY ACT RESOURCE GUIDE
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HOW TO USE THIS RESOURCE GUIDE

This Resource Guide offers providers and consumers essential guidance on the application of the Mental Health Parity and Addiction Equity Act (Parity Act) to public and private health insurance offered in Maryland. The goal is to help identify whether insurance companies and entities that administer Medicaid are limiting the scope or duration of treatment for mental health and substance use disorders (MH/SUD) or requiring patients to pay more for their MH/SUD care, in violation of the Parity Act. This guide identifies the standards put in place by federal Parity Act regulations issued in November 2013 and Maryland's state parity law.

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INTRODUCTION TO THE FEDERAL PARITY ACT

The Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) is intended to end discrimination in health insurance coverage for persons with mental health and substance use disorders (MH/SUD). The law requires **large employers** that offer health insurance that includes MH/SUD benefits to provide coverage that is on par with coverage for medical/surgical (M/S) conditions. The Parity Act does not mandate that a plan provide MH/SUD benefits. But if a large employer's commercial (fully insured) or self-insured health plan does provide MH/SUD benefits, then it must follow parity standards. In Maryland, all large group commercial plans must provide MH/SUD benefits, and they must provide coverage that complies with the Parity Act.

Additionally, the Affordable Care Act (ACA) requires **all individual and small group health plans** sold in the commercial market after January 2014 to provide MH/SUD benefits and to comply with the Parity Act standards. All individual and small group plans sold on Maryland Health Connection or in the commercial market provide comprehensive MH/SUD benefits.

Finally, the Parity Act requires Medicaid managed care organizations that offer MH/SUD benefits to provide those benefits on par with M/S benefits. Under the ACA, Medicaid benefits that are delivered to the newly eligible population must also cover MH/SUD benefits and must comply with the Parity Act regardless of whether a managed care organization (MCO) or a non-managed care arrangement, such as an administrative services organization (ASO), delivers the health benefits. In Maryland, substance use disorder benefits, which are currently provided by Medicaid MCOs, must comply with the Parity Act, and mental health benefits, provided through an ASO, must also comply under the ACA.

- **Basic Parity Standards.** The Parity Act prohibits health plans from providing MH/SUD benefits that are more restrictive than the M/S benefits they offer, with respect to the following coverage features:
  - **Financial requirements**, such as copays, deductibles, and other cost-sharing requirements
  - **Quantitative treatment limitations**, such as day limits and visit limits
  - **Non-quantitative treatment limitations**, plan design features that limit the scope or duration of treatment, including medical management, medical necessity and authorization standards, provider network standards and reimbursement rates, and fail-first policies.
  - **Annual and lifetime dollar limits** on benefit payments
- **Classifications.** Benefits for MH/SUD are compared with M/S services within each of six classifications.
  - Outpatient, in-network
  - Outpatient, out-of-network
  - Inpatient, in-network
  - Inpatient, out-of-network
  - Emergency care
  - Prescription drugs
- **Parity Standard for Financial Requirements and Quantitative Treatment Limitations.** The federal parity law prohibits applicable health plans from imposing financial requirements (such as co-pays and deductibles) or treatment limitations (such as visit limits) on MH/SUD benefits that are **separate from** or **more restrictive** than the **predominant** requirements or limitations applied to **substantially all** M/S benefits in the same classification.
- **Parity Standard for Non-quantitative Treatment Limitations.** A health plan cannot impose plan management standards for MH/SUD benefits that are **not comparable** to the standards used for M/S benefits and cannot apply those standards **more stringently** for MH/SUD benefits.
- **Required Disclosures.** Plans must make certain information available, free of charge, with regard to MH/SUD

benefits and adverse decisions.

- **Medical Necessity Criteria.** Criteria for medical necessity determinations with regard to MH/SUD benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request.
- **Denials of Reimbursement or Payment for Services.** The reason for any denial of reimbursement or payment for services with regard to MH/SUD benefits must be made available within a reasonable time to the participant or beneficiary, upon request or as otherwise required.
- Please see page 16 for more information on the required disclosures.

MARYLAND'S PARITY LAW

- **Standards.** Maryland's parity law mandates coverage for MH/SUD treatment, including outpatient treatment, partial hospitalization and inpatient treatment.
- **Scope.** Maryland's parity law applies to large group fully insured health plans and individual health policies sold in Maryland. It does not apply to small group health plans. The ACA and Maryland's benchmark plan now require all individual and small group health plans sold in the commercial market to offer a wide range of MH/SUD benefits in their plans and to ensure those benefits are designed in compliance with the federal Parity Act.
- **Effect.** In Maryland, large group health plans that are sold on the commercial market must provide MH/SUD treatment and must comply with the federal Parity Act. Individual policies and small group plans, other than self-insured small group plans and grandfathered small group plans, must comply with the Parity Act.

MEDICAID

In Maryland, SUD services that are delivered through managed care organizations (MCOs), including MH/SUD benefits provided to the newly eligible expansion population through an MCO or the administrative services organization (ASO) must comply with the Parity Act. The Centers for Medicare & Medicaid Services (CMS) have provided guidance on parity compliance for Medicaid benefits dated Nov. 2009 and Jan. 2013. Specifically, Medicaid MCO plans must:

- Ensure that financial requirements (such as deductibles, co-payments, co-insurance, and out-of-pocket expense limits) applicable to MH/SUD benefits are no more restrictive than the predominant financial requirements applied to substantially all M/S benefits in the State's benefit plan
- Ensure that treatment limitations (both quantitative and non-quantitative) for MH/SUD benefits are no more restrictive than those imposed on M/S benefits
- Provide out-of-network coverage for MH/SUD benefits if M/S benefits may be delivered by out-of-network providers
- Provide information regarding criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

PLAN TYPE AND APPLICABLE PARITY LAW

Plan Type	Applicable Law	Required Coverage MH/SUD Benefits
Individual Health Policy	Federal Parity Act and ACA	▪ MH/SUD Benefits – Maryland Benchmark Plan ▪ Parity Compliance
Small Group Plan Commercial Market	Federal Parity Act and ACA	▪ MH/SUD Benefits – Maryland Benchmark Plan ▪ Parity Compliance
Small Group Plan Self-Insured	No Parity Law Applies	▪ No requirement that plan provide MH/SUD Benefits ▪ No requirement to comply with Parity if the plan does provide MH/SUD Benefits
Large Group Plan Commercial Market	Federal Parity Act and Maryland Parity Law	▪ Maryland - MH/SUD Benefits ▪ Parity Compliance
Large Group Plan Self-Insured	Federal Parity Act	▪ If the plan provides MH/SUD benefits, they must be provided in Parity
Medicaid – MCO and ASO	Federal Parity Act through ACA and CMS Letters and State Law	▪ Medicaid/HealthChoice MH/SUD benefits ▪ Parity Compliance

INDIVIDUAL POLICY

Plan Type	Applicable Law	Scope of Mental Health and Substance Use Disorder Benefits Required
Individual Health Policy	Federal Parity Act and ACA	▪ Professional Services by Licensed Professionals o Diagnosis and Treatment ▪ Diagnostic evaluation; ▪ Crisis intervention and stabilization for acute episodes; ▪ Medication evaluation and management (pharmacotherapy); ▪ Treatment and Counseling (including individual or group therapy visits); ▪ Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling; ▪ Professional charges for intensive outpatient treatment in a provider's office or other professional setting o Electroconvulsive Therapy; o Inpatient professional fees; o Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner; o Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; o Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment. ▪ Outpatient Hospital - services such as partial hospitalization or intensive day treatment programs ▪ Inpatient Hospital and Inpatient Residential Treatment Centers o Room and board; o Other facility services and supplies ▪ Emergency room - outpatient services and supplies billed by a hospital for emergency room treatment ▪ Prescription Drug Benefit o Must provide, at a minimum, two medications for both alcohol and drug dependence
Individual Health Plans-Grandfathered	Maryland Parity Law and Federal Parity Act ▪ Md. Code Ann., Ins. § 15-802	▪ Outpatient o Must be covered under the same terms and conditions that apply to similar benefits available under the contract for physical illness ▪ Partial Hospitalization - at least 60 days for MH/SUD ▪ Inpatient o Same number of days for MH/SUD as M/S

SMALL GROUP PLANS

Plan Type	Applicable Law	Scope of Mental Health and Substance Use Disorder Benefits Required
Small Group Plans (50 or fewer employees) Commercial Market	Federal Parity Act and ACA	▪ Professional Services by Licensed Professionals o Diagnosis and Treatment ▪ Diagnostic evaluation; ▪ Crisis intervention and stabilization for acute episodes; ▪ Medication evaluation and management (pharmacotherapy); ▪ Treatment and Counseling (including individual or group therapy visits); ▪ Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling; ▪ Professional charges for intensive outpatient treatment in a provider's office or other professional setting o Electroconvulsive Therapy; o Inpatient professional fees; o Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner; o Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; o Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment. ▪ Outpatient Hospital - services such as partial hospitalization or intensive day treatment programs ▪ Inpatient Hospital and Inpatient Residential Treatment Centers services o Room and board; o Other facility services and supplies. ▪ Emergency room - outpatient services and supplies billed by a hospital for emergency room treatment ▪ Prescription Drug Benefit o Must provide, at a minimum, two medications for both alcohol and drug dependence
Small Group Plan Self-Insured	No Parity Law Applies	▪ No requirement to provide MH/SUD Benefits
Small Group Plan Commercial Market Grandfathered	No Parity Law Applies. State Law COMAR 31.11.06.03 and 31.11.06.05	▪ Inpatient Hospitalization- 60 Days o Detoxification ▪ Partial Hospitalization 2 Days for 1 Inpatient day ▪ Outpatient- Cost-sharing: 70% Carrier, 30% Enrollee (in-network) and 50% Carrier, 50% Enrollee (out-of-network) ▪ Services must be accessed through Managed Care System

LARGE GROUP PLANS

Plan Type	Applicable Law	Scope of Mental Health and Substance Use Disorder Benefits Required
Large Group Plan (50+ Employees) - Commercial Market	Federal Parity Act Maryland Parity Law ▪ Md. Code Ann., Ins. § 15-802	▪ Outpatient* o Must be covered under the same terms and conditions that apply to similar benefits available under the contract for physical illnesses ▪ Partial Hospitalization - at least 60 days for MH/SUD ▪ Inpatient o Same number of days for MH/SUD as M/S
Large Group Plan (50+ Employees)- Self Insured	Federal Parity Act	▪ No mandated scope of services ▪ If MH/SUD benefits are provided, they must be in parity with M/S benefits

* Maryland's large employers that are commercially insured must comply with the Parity Act because they are required to provide MH/SUD benefits under the Maryland parity law. This means that the scope of benefits, required by state law, is the narrowest scope of benefits that the large employer can provide. The scope of benefits for MH/SUD benefits must be comparable to the scope of M/S benefits. 29 CFR § 2590.712(c)(2)(ii).

MEDICAID MANAGED CARE ORGANIZATIONS
SUBSTANCE USE DISORDER BENEFITS

Plan Type	Applicable Law	Scope of Substance Use Disorder Benefits
Medicaid - Managed Care Organization (MCO)	Federal Parity Act ▪ CMS Guidance Letters (Nov. 2009, Jan. 2013) State Law COMAR. § 10.09.67.10, 10.09.65.04, and 10.09.65.11	HealthChoice Benefit: ▪ Comprehensive Assessment; ▪ Information and Referral ▪ Coordination of Care ▪ Outpatient Individual and Group Counseling; ▪ Intensive Outpatient services; ▪ Opioid Maintenance Treatment; ▪ Partial Hospitalization in hospital setting; ▪ Residential and Inpatient Treatment for Persons Under 21 ▪ Medically Managed Inpatient Detoxification ▪ Case Management for individuals with HIV, pregnant or postpartum women and other persons with SUD ▪ Prescription Drugs

PARITY ACT STANDARDS AND "RED FLAGS" TIPS FOR IDENTIFYING PARITY ACT VIOLATIONS

PLAN FEATURES REGULATED BY THE PARITY ACT

Financial Requirements

A health plan regulated by the Parity Act that provides MH/SUD benefits may not apply any financial requirement to those benefits that is more restrictive than the predominant financial requirement of the type that is applied to substantially all medical/surgical benefits in the same classification. **A financial requirement may not be applied to MH/SUD benefit unless it applies to 2/3 of the M/S benefits. The level of the financial requirement applied to MH/SUD benefits can be no greater than the level applied to 51% of the M/S benefits. The carrier has the data needed to make these calculations.** The financial requirements most often applied to plans are listed below.

FINANCIAL REQUIREMENTS	
Copayment	The dollar amount the patient is expected to pay at the time of service.
Coinsurance	A percentage of the cost of covered treatment that a patient must pay after the deductible is met.
Deductible	The dollar amount the patient must pay before the insurer will pay for any MH/SUD treatment. Plans cannot have a separate deductible for MH/SUD benefits (*e.g.*, a deductible that applied to MH/SUD benefits, but not M/S benefits)
Out-of-Pocket Maximum	The total amount a patient is required to pay towards the cost of MH/SUD treatment.
Admission Fee	The dollar amount that the patient is expected to pay at the time of admission for MH/SUD treatment.
Aggregate Lifetime Dollar Limits	The total dollar amount the plan will pay for MH/SUD treatment over the course of the patient's life. The ACA prohibits annual and lifetime limits on all essential health benefits, which includes MH/SUD benefits. Individual and small group commercial plans, and any plan that provides MH/SUD benefits that satisfies a definition of essential health benefits that has been approved by the Secretary of HHS, cannot place annual or lifetime limits on MH/SUD benefits. For example, a small group, self-insured plan with a benefit approved as an essential health benefit, may not impose an annual or lifetime limit on that benefit.
Annual Dollar Limits	The total dollar amount the plan will pay for MH/SUD treatment in a 12-month period.

Quantitative Treatment Limitations

Quantitative treatment limitations are regulated in the same fashion as financial requirements. **A quantitative treatment limitation may not be applied to MH/SUD benefit unless it applies to 2/3 of the M/S benefits. The level of the quantitative treatment limitation applied to MH/SUD benefits can be no greater than the level applied to 51% of the M/S benefits.** The carrier has the data needed to make these calculations. The treatment limitations that are most often applied to plans are listed below.

TREATMENT LIMITATIONS	
Limits on Frequency of Treatment	A numerical limit on the frequency of MH/SUD treatment that the patient may receive.
Limits on Number of Visits	A limit on the number of visits for MH/SUD treatment allowed under the patient's plan, usually for outpatient treatment.
Limits on Number of Days	A limit on the number of days for MH/SUD treatment or service allowed under the patient's plan, usually for inpatient treatment.
Length of Stay Per Episode	A limit on the length of MH/SUD treatment or service allowed per episode.

Nonquantitative treatment limitations

Nonquantitative treatment limitations include medical management standards and all plan features that may limit the scope or duration of benefits. The Parity Act requires that the standards used to impose these limitations on MH/SUD benefits be comparable to the standards used for M/S benefits. For example, a plan must use comparable criteria for MH/SUD and M/S benefits in determining whether prior authorization is applied to MH/SUD and M/S benefits. Additionally, these standards cannot be applied more stringently to MH/SUD benefits than to M/S benefits. An illustrative list of nonquantitative treatment limitations is provided below.

NON-QUANTITATIVE TREATMENT LIMITATIONS	
Exclusions	Based on failure to complete treatment.
Authorization	▪ Pre-Authorization: the insurer reviews care before treatment begins for medical necessity. ▪ Concurrent Authorization: the insurer reviews care periodically to assess continued medical necessity. ▪ Retrospective Authorization: the insurer reviews care after the treatment has been performed for medical necessity.
Medical Necessity Criteria	Criteria used by health insurance plan to determine whether treatment or services are "medically necessary" before providing reimbursement or coverage. ▪ Includes "medical appropriateness" standards: whether the treatment is deemed experimental or investigative
"Fail First" Policies	The patient must fail using one medication or in one level of treatment before another is approved.
Step Therapy Protocols	The patient must first try the least expensive care before being allowed to try the next least expensive care.
Provider Admission to Carrier Networks	Including reimbursement rates and provider network criteria.
Service Reimbursement	Plan methods for determining usual, customary, and reasonable charges.
Plan standards that limit the scope or duration of benefits	Restrictions based on geographic location (such as services accessed outside of the state), facility type (whether services are accessed in a hospital or residential treatment center), provider specialty (such as an exclusion for services provided by a clinical social worker), and other criteria that limit the scope or duration of benefits for services provided.
Prescription Drugs	Formulary design.
Network Tiers	Preferred providers and participating providers network tier design.

TIPS FOR IDENTIFYING PARITY ACT VIOLATIONS "RED FLAGS"

1. **Look for red flags.** It may be difficult to identify Parity Act violations because providers and consumers of MH/SUD services often have no way of knowing the kinds of restrictions that a health plan imposes on M/S services and do not have plan data needed to determine whether a financial requirement or a treatment limitation is permitted. The following "red flags" are specific examples of common restrictions that raises a possible parity violation and warrants further investigation

   - **Separate deductibles for MH/SUD and M/S services.** The parity regulations prohibit plans from using a deductible for MH/SUD services that accumulates separately from any deductible for M/S services. Even if the level of the two deductibles is identical, they do not comply with the Parity Act if they accumulate separately. In other words, expenses for MH/SUD and M/S services must accumulate together to satisfy a single "combined deductible."

   - **Limits on the number of visits or days of MH/SUD treatment.** Some plans apply visit or day limits to MH/SUD services, and those limits are often not applied to M/S services generally. Even if some specific M/S services, like physical or occupational therapy, are subject to these visit limitations, that is not enough to justify limitations on MH/SUD care. The visit limits must apply to at least 2/3 of the M/S benefits to be imposed on MH/SUD services and the level of the limitation on MH/SUD benefits can be no greater than the limit that applies to 51% of M/S benefits.

   - **High copayments or coinsurance requirements for MH/SUD treatment.** If a copayment (what you must pay at the time of service) or coinsurance requirement (the percentage that you must pay after the deductible is met) seems unusually high, it may be more restrictive than the requirements applied to M/S services. If the copayment for MH/SUD outpatient visits is the same as the copayment for a M/S "specialist" and higher than the copayment for a primary care physician, the plan must demonstrate that the "specialist" copayment is the predominant value for outpatient visits.

   - **Financial requirements for MH/SUD prescription drugs that seem more restrictive than those for M/S prescription drugs.** Plans are permitted to impose different financial requirements on different tiers of prescription drug benefits and still be parity-compliant. But any differences in tier coverage must be based on "reasonable factors" (such as cost, efficiency, and generic versus brand name), not on whether the drugs are generally prescribed for MH/SUD or M/S conditions.

   - **Exclusions that seem to apply only to MH/SUD services.** For example, some plans exclude coverage for court-ordered treatment, treatment related to illegal activity or legal charges, or addiction services that are not "voluntary." Because the kinds of treatment affected are almost exclusively MH/SUD services, plans applying these exclusions are very likely in violation of the Parity Act.

   - **"Fail-first" or "step therapy" requirements for MH/SUD treatment.** Sometimes, before agreeing to cover a certain level of care or medication, plans will require patients to fail first at less intensive levels of care or less expensive medications. If plans apply these requirements, they must be comparable to and applied no more stringently than those applied to M/S benefits in order to comply with the Parity Act.

- **Authorization standards for MH/SUD services (*e.g.*, precertification, concurrent review, treatment plan requirements) that seem especially burdensome.** Plans often apply some authorization standards for all kinds of services. But if they require providers to obtain authorization for MH/SUD services at earlier stages of treatment or with greater frequency (for example, every 5 outpatient visits), or they apply their authorization standards more restrictively to such services, then they are likely in violation.

- **Limitations or exclusions of intermediate levels of care for MH/SUD Benefits (*e.g.* residential treatment).** The scope of services for MH/SUD benefits must be comparable to the scope of services for M/S. If a plan covers intermediate levels of care for M/S, such as skilled nursing facilities or rehabilitation hospitals, it may not exclude comparable services for MH/SUD care, such as residential treatment. The plan must also cover the intermediate levels of care for MH/SUD in compliance with the QTL and NQTL requirements of the Parity Act (*e.g.*, no more restrictive limitations on the length of stay for MH/SUD benefits than M/S benefits or more stringent authorization standards).

- **Limitations on location for accessing MH/SUD Benefits.** If a plan limits the geographic location (*e.g.* must access the benefit from an in-state provider), or the type of facility in which a MH/SUD benefit can be accessed, but does not impose similar restrictions on M/S benefits, a Parity Act violation may exist. For example, a plan cannot deny an enrollee coverage for MH/SUD treatment received out-of-state if it covers M/S benefits in the same classification out-of-state.

2. **Always Request (a) the reason for denial and (b) the medical necessity criteria.** Every time that a plan denies a claim for payment or reimbursement for MH/SUD service, or the insurer substitutes a lower level of care than the one requested, you should contact the patient's health plan and request this information (if it has not already been provided). The Parity Act requires insurers to make these disclosures to any plan participant, "contract provider" or beneficiary upon request. You should request not only the medical necessity criteria for MH/SUD benefits, but also the criteria for comparable M/S benefits, so that the standards can be compared.

3. **Obtain Description of the Patient's Benefits.** To determine if the parity law has been violated, you must compare the standards for MH/SUD with those for M/S benefits within the same classification. You will need a description of both the MH/SUD and M/S benefits under the plan. Persons enrolled in a plan should receive the benefit description and may request this from the plan administrator**.**
   - **Conduct a Comparison.** Compare the M/S benefits that are in the same classification as the MH/SUD benefit you are examining. For example, if you are concerned that the plan imposes a higher co-payment for MH/SUD in-network, outpatient benefits than it imposes on M/S benefits, compare the MH/SUD outpatient financial requirements with those placed on M/S in-network, outpatient benefits.

Next Steps

If you think that there may be a potential violation of the Parity Act, you should initiate the insurer's internal grievance process or Maryland's Medical Assistance appeal process.

Also, without disclosing any patient information, please e-mail the Drug Policy Clinic and provide a brief description of the reason for denial or description of the potential parity violations.

- *Example:* Insurance company (by name) refused coverage for intensive outpatient treatment because it wanted the patient to go to AA first.

DISCLOSURE PROVISIONS

REQUIRED DISCLOSURES FROM INSURERS TO PARTICIPANTS, BENEFICIARIES, AND CONTRACTING PROVIDERS

Objective

Federal and Maryland parity laws and regulations require an insurer to provide certain disclosures, upon request and free of charge, to requesting participants, beneficiaries, and contracting providers.

If an insurer is unwilling to provide reason(s) for denial and/or medical necessity criteria, **this document provides the essential standards to support the disclosures of such information. The citation to the law is identified below.**

REQUIRED DISCLOSURES UNDER THE PARITY ACT

1. **The criteria used for MH/SUD medical necessity determinations must be made available to current and potential participants, beneficiaries, or contracting providers, upon request.**

   The specific language from the law is:

   > The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request.

2. **The reasons for denial of reimbursement or payment for MH/SUD services must be made available to participants or beneficiaries, upon request.**

   The specific language from the law is:

   > The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

REQUIRED DISCLOSURES UNDER ERISA OR STATE REGULATIONS

The Parity regulations make clear that plans must additionally comply with the disclosure requirements of all other applicable Federal or State laws. For example, non-governmental large and small group plans, subject to ERISA, must provide to plan administrators or plan participants within 30 days of request, instruments under which the plan is established or operated. This disclosure requirement encompasses documents with information on medically necessity criteria for M/S and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to M/S and MH/SUD benefits under the plan.

REQUIRED DISCLOSURES UNDER MARYLAND LAW

In Maryland, a copy of the specific criteria and standards used in conducting utilization review of proposed or delivered services must be furnished by the private review agent upon written request of any person or healthcare facility.* When conducting a utilization review for MH/SUD benefits, a plan or private review agent must ensure that the criteria and standards are in compliance with the Parity Act.

GUIDANCE FOR APPEALS

APPEALS FOR PRIVATE INSURANCE CLAIMS

<table>
<tr><td>EXHAUST INTERNAL APPEALS PROCESS</td><td colspan="2">For adverse benefit determinations, Maryland state law requires patients to exhaust the plan's internal appeals process first.
The Maryland Attorney General's Health Education and Advocacy Unit can assist with the internal appeals process.
Note: The appeal may address two different issues —
The appeal may address the merits of the claim (i.e., the patient does, in fact, meet medical necessity criteria for the denied treatment); or
The appeal may address violations of parity (i.e., the medical management criteria used to deny coverage violates parity).</td></tr>
<tr><td rowspan="3">FILE AN APPEAL WITH STATE OR FEDERAL AGENCY</td><td colspan="2">If the patient is not satisfied after exhausting the internal appeals process, an appeal may be filed with the following government agencies, depending on the type of insurance plan involved.</td></tr>
<tr><td colspan="2">For fully insured plans, file an appeal with the Maryland Insurance Administration (MIA).
For more details, go to: http://www.mdinsurance.state.md.us/sa/consumer/file-a-complaint.html</td></tr>
<tr><td colspan="2">For self-insured plans, file an appeal with the Department of Labor.
For more details, go to: http://www.dol.gov/ebsa/publications/how_to_file_claim.html</td></tr>
<tr><td rowspan="2">AGENCIES TO GO TO FOR HELP</td><td>If state law or both federal and state laws apply…</td><td>Contact Maryland Insurance Administration, Life and Health Complaint Unit, at (410) 468-2000 or 1-(800) 492-6116.
You can also contact the Health Education and Advocacy Unit at 1-(877) 261-8807.</td></tr>
<tr><td>If only federal law applies…</td><td>Only the U.S. Department of Labor or Centers for Medicare & Medicaid Services can address these appeals.
Contact CMS for parity complaints related to plans purchased on the Exchange: MarketPlaceImplementation@cms.hhs.gov.
Contact an ERISA benefit advisor at (202) 693-8700.</td></tr>
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RELEVANT TIMEFRAMES FOR FILING AND APPEALING PRIVATE INSURANCE CLAIMS

1.	**File a Request for Services with Your Insurer**
	File a service request with your insurer to determine whether the insurer will authorize or certify a course of treatment.
	The insurer must render its decision and get back to you: • Within 2 hours for emergency treatment, including residential crisis services for a MH/SUD. • Within 2 working days for non-emergency treatment.
2.	**File a Grievance with Your Insurer**
	If you are dissatisfied with the insurer's adverse decision, you may file a **grievance** with the insurer. • However, you are allowed to bypass this step by filing a complaint directly with the Commissioner of MIA if you have a **compelling reason**.* If you have a compelling reason, then skip directly to Step Three, *File a Complaint with the Commissioner of the MIA*.
	The insurer must render its decision on your grievance and get back to you: • Within 24 hours of being filed for emergency treatment. • Within 30 working days of being filed for non-emergency treatment or services that have not yet been delivered. • Within 45 working days of being filed for non-emergency treatment or services that have already been delivered (a retrospective denial).
	If the insurer does not render its decision and get back to you within these timeframes, you may file a complaint directly with the Commissioner of the MIA within **4 months**.
3.	**File a Complaint with the Commissioner of the Maryland Insurance Administration (MIA)**
	You may file a complaint with the Commissioner if: • You have a compelling reason (see above); • The insurer did not render its decision within the appropriate time frames (see above); or • You are dissatisfied with the insurer's final decision, and you file a complaint with the Commissioner within **4 months of receiving the decision**.
	After you file a **complaint**, the Commissioner must render its decision: • Within 24 hours for emergency treatment. • Within 45 days for non-emergency treatment.
4.	**Appeal the Commissioner's Decision**
	If you are dissatisfied with the Commissioner's decision, you may appeal within **30 days** of receiving the Commissioner's decision for: • **Administrative review by the MIA** (usually delegated to the Office of Administrative Hearings); or • **Judicial review** with the appropriate State circuit court.

* A compelling reason includes a showing that potential delay imposed by filing with the insurer could result in loss of life, serious impairment or bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.

APPEALS FOR MEDICAID CLAIMS	
MCO INTERNAL GRIEVANCE PROCESS	▪ If you are dissatisfied with the MCO's adverse decision, you may file a complaint with the MCO. The MCO must review and return a decision: o Within 24 hours for emergency medically-related grievances o Within 5 days for non-emergency medically-related grievances o Within 30 days for administrative grievances ▪ If you are dissatisfied with the MCO's grievance decision, you may file an appeal with the MCO within 90 days of the decision. ▪ Time Frame for Appeal Decisions o The MCO must resolve the appeal within 30 days of receiving the appeal, with a 14-day extension in certain circumstances. o Expedited appeals are available and must be resolved within 3 business days if the 30-day resolution period would severely damage your health. ▪ Continuation of Benefits o You may continue to receive your benefits pending the outcome of the appeal, if you file the appeal within 10 days of the notice of action or effective date of MCO's action. ▪ Procedural Rights o MCOs must allow you to present evidence and see your record. ▪ Requesting a Fair Hearing o You may request a fair hearing from DHMH within 90 days of the initial adverse decision by your MCO; or o You may request a fair hearing from DHMH within 10 days following an adverse appeal decision by your MCO.

APPEALS TO DEPARTMENT OF HEALTH AND MENTAL HYGIENE	▪ You may file a complaint with DHMH without going through the MCO's internal grievance and appeal process. o DHMH will determine if the MCO's decision to deny, reduce, suspend, or terminate your benefit or service was improper. o If DHMH disagrees with the MCO's determination, the Department may order the MCO to provide the benefit or service immediately. ▪ Appeal of DHMH Decision o If you do not agree with DHMH's finding, you may appeal the decision to the Office of Administrative Hearings (OAH) within 90 days of receiving notice from the MCO of your right to a fair hearing. o If appealing a denial of benefit or service based on medical necessity, and the hearing meets the DHMH's criteria for an expedited hearing, the OAH must schedule a hearing and render a decision within 3 days. o For all other appeals, the OAH must schedule a hearing within 30 days and issue a decision within 30 days of the hearing. ▪ Appealing OAH Decisions o You may appeal the decision to the Board of Review within 30 days of the decision with further appeal to the circuit court. o You may appeal directly to circuit court without first appealing to the Board of Review