EQUAL INSURANCE COVERAGE
OF SUBSTANCE USE AND
MENTAL HEALTH DISORDERS

IT'S THE LAW.

Best Practices Guide to Improve the Parity Complaint Process

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Executive Summary

State insurance regulators rely heavily on consumer complaints to identify the scope and nature of insurance carrier violations of state and federal parity laws. Yet the volume and frequency of consumer complaints about mental health and substance use disorder service denials do not reflect the magnitude of parity violations, which have been well documented by state attorney general investigations, court decisions and department of insurance market examinations.

State policymakers and insurance regulators can do more to assist consumers in identifying and reporting possible parity violations and filing complaints to challenge discriminatory limits on mental health substance use disorder benefits. The Parity at 10 Campaign has developed the *Best Practices Guide to Improve the Parity Complaint Process* to highlight effective consumer assistance practices that states have implemented to support consumers and treatment providers. Implementing an effective parity complaint process will help consumers access the treatment that they are entitled to receive and help state regulators enforce parity protections.

The Best Practices Guide identifies four key elements of an effective Parity Complaint Process.

- A simple complaint process that allows consumers and providers to ***notify*** state regulators of potential parity violations without filing a formal complaint.
- A consumer assistance program that works directly with consumers to ***explain insurance rights and file complaints.***
- Effective outreach and education about parity laws and basic insurance practices to ***inform*** consumers about their rights and available assistance.
- A coordinated data collection system that gathers information about claims, adverse decisions and complaints and is used by regulators to ***identify trends*** that result from underlying parity violations.

The Guide identifies state models for each element and includes a Sample Mental Health and Addiction Parity Complaint Form.

To assist with the implementation of an effective Parity Complaint Process, the Guide offers a step-by-step plan to help state stakeholders assess their state's existing complaint framework and systematically improve the complaint process for parity enforcement.

Learn More

Learn more about the Parity at 10 Campaign at parityat10.org.

Background

State insurance regulators rely heavily on consumer complaints to identify the scope and nature of insurance violations of state and federal laws, including the Mental Health Parity and Addiction Equity Act (Parity Act) and state parity laws. In the absence of Parity Act complaints, regulators often conclude that insurers are complying with parity requirements. Provider and consumer experiences, independent research[1], state attorney general investigations[2] and market conduct examinations[3] demonstrate that insurers routinely violate the Parity Act's non-discrimination standards. Yet, the volume and frequency of consumer complaints about mental health and substance use disorder (MH/SUD) service denials and limitations do not reflect the scope of the problem.[4]

Consumer complaints play an important role in parity compliance efforts. Complaints help consumers get the services they are entitled to through their insurance plans; they help regulators target systemic insurer practices that are unlawful; and they help policymakers identify state standards that require legislative or regulatory reform to improve enforcement efforts. Still, stakeholders in most states struggle to identify effective processes that will support consumers in identifying insurance violations and filing insurance complaints related to mental health or substance use disorder benefit coverage and reimbursement.[5]

In response to technical assistance requests from state partners in the Parity at 10 Campaign, the Legal Action Center has prepared this toolkit, *Best Practices Guide to Improve the Parity Complaint Process*, to help states address the parity complaint conundrum. The toolkit provides recommendations and strategies to improve or develop more effective parity complaint practices in states. The Legal Action Center informally surveyed national parity experts to identify states that have implemented effective consumer assistance practices and

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[1] Milliman, "Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates," Dec. 2017, *available at* **http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf**.

[2] New York State Office of the Attorney General, Health Care Bureau, "Mental Health Parity: Enforcement by the New York State Office of the Attorney General, May 2018, *available at* ***https://ag.ny.gov/sites/default/files/hcb_mental_health_parity_report.pdf***.

[3] New Hampshire Insurance Dept., Market Conduct Targeted Examination of Harvard Pilgrim Health Care of New England, Inc. Regarding the Handling of Substance Use Disorder Benefits and Mental Health Parity, Feb. 7, 2017 available at **https://www.nh.gov/insurance/reports/documents/030217-nhid-substance-use-disorder-exam-report-harvard-pilgrim.pdf** at 45-48 (finding violations of reimbursement rate standards).

[4] Texas Dept. of Insurance, "Study of Mental Health Parity to Better Understand Consumer Experiences with Accessing Care," Aug. 2018 *available at* **https://www.tdi.texas.gov/reports/documents/Final-draft-HB-10-report-8.31.18.pdf**. (finding that "the number of complaints reported [by carriers] for medical surgical services were significantly higher than those reported for mental health and substance use disorders" but noting that "the low number of mental health and substance use disorder complaints does not necessarily mean an absence of claims problems" as "consumers are reluctant to complain due to a perceived stigma" about these disorders. Study at 10.).

[5] The Department of Health and Human Services offers a Mental Health and Addiction Insurance Help portal that helps consumers identify the state or federal agency that has enforcement authority based on type of insurance, but the portal does not provide consumer assistance. **https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html**.

then closely examined consumer and provider complaint practices in nine states – Colorado, Connecticut, Illinois, Maryland, New York, New Jersey, Ohio, Pennsylvania, and Texas – to identify best practices that are replicable. The research included interviews with government officials and advocates and a web search for relevant information. The list of experts who were consulted for this toolkit is provided in Exhibit A.

For this toolkit, we define the ***Parity Complaint Process as a method by which a consumer or provider can notify an agency responsible for state and federal parity law enforcement of a possible parity violation.*** This can include, on one end of the spectrum, a consumer hotline to alert the agency of an individual or systemic problem that may indicate a state or federal parity violation or, on the other end, a formal complaint with the state department of insurance or state Medicaid office or the federal Department of Labor or Center for Medicare and Medicaid Services. Within this framework, an ***informal complaint process or problem notification system*** would allow a consumer or provider to call a hotline or send a general email to express concerns about a health plan standard or plan design feature that limits access to MH/SUD services. A ***formal complaint process*** would require an individual consumer or provider to file a complaint form or letter that sets out the facts of an alleged parity violation relating to a plan's financial requirement, a quantitative treatment limitation, a non-quantitative treatment limitation or disclosure practice.

While the Parity Complaint Process may overlap with an individual grievance/appeal process for challenging an adverse decision, it is intended to be a distinct process from that established under state and federal law to resolve coverage and benefit denials. States should offer a stand-alone Parity Complaint Process because many parity violations will not involve an adverse decision. For example, a consumer or provider may wish to complain about a limited provider network, low provider reimbursement rates or allowable amount determinations, or the placement of MH/SUD medications on the most expensive formulary tiers. These plan standards may not result in a denial of service or reimbursement, but they do limit access to care and could be grounded in a parity violation. Effective enforcement of parity laws requires investigations of both informal and formal complaints, as well as an assessment of parity violations that are implicated in an adverse benefit decision.

This toolkit highlights strategies that stakeholders should consider to improve parity problem identification across this spectrum. While most state experts have focused on the needs of commercially insured consumers, the strategies outlined below are equally applicable to the Medicaid market. The toolkit summarizes the practices, as well as provides some implementation guidance for stakeholders to consider as they work toward strong parity law enforcement in their state.

This toolkit does not examine the limitations of or recommend changes to the internal appeal or external review insurance appeal process. The appeal process is subject to state and federal regulation and would involve systemic reform to improve those practices. The implementation

of a Parity Complaint Process will, however, provide regulators with a more complete picture of MH/SUD benefit denials, which are not challenged routinely through the standard appeal process. Finally, the toolkit focuses on best practices supported by the research, but it may overlook some promising strategies as not all states' processes have been examined.

It is important to note that parity experts do not believe a complaint-driven process is the most effective way to enforce the Parity Act and state parity laws. The Parity at 10 Campaign recommends that regulators adopt a pre-market enforcement process, including pre-market plan review with specific data submission requirements for plans, and post-market conduct exams to achieve improved enforcement. These enforcement tools should be supplemented with a strong Parity Complaint Process, but ***a complaint strategy should not be considered a substitute for comprehensive compliance review,*** as required by the recent U.S. Department of Labor guidance.

Summary of Findings

Interviews with consumer advocates and state government staff and relevant internet research identified key "best practices" to serve as a foundation for a strong state-based Parity Complaint Process (hereafter "complaint process").

A model Parity complaint process should:

- Be easy to navigate
- Be widely communicated
- Serve consumers and providers
- Include consumer assistance to help individuals appeal adverse decisions and file formal parity complaints
- Serve as a source of data collection to drive future enforcement actions

For any complaint process to be effective it must be easy to understand and navigate, well communicated and available for both consumers and providers to use. The process must be responsive to those who use it, and the "customer" must gain confidence that it will result in a positive resolution of their complaint to devote the time and resources required to participate in the process. Even with a simple process, many individuals who are addressing a mental illness or substance use disorder in their family do not have the time or capacity to understand their insurance and parity rights and, subsequently, file an internal appeal, external review, or a formal parity complaint. Therefore, states should consider implementing a consumer assistance or ombuds program focused specifically on behavioral health (or adding behavioral health expertise to an existing health insurance ombuds program) to provide individualized assistance to consumers. Additionally, strong data collection processes must be in place so that regulators can identify patterns of violations presented via informal and formal complaints, enabling them to address systemic violations through a pre-market compliance review.

Best Practices

The elements of a strong consumer and provider Parity Complaint Process are components of a holistic process. ***Each state must assess its current consumer assistance process, identify strengths to be leveraged and gaps in capacity, and develop a plan to adopt a comprehensive and consumer-friendly process.*** The practices and elements vary in resource requirements, but each can be modified based on available resources. A summary of the Best Practices Recommendations is provided in Exhibit B.

1) Implement a Simple, Inclusive, Consumer-Friendly Complaint Process

Parity stakeholders should work with their state parity enforcement authority to develop a comprehensive, easy to navigate process that allows consumers and providers to notify regulators of possible parity problems and to file formal parity complaints for private insurance and Medicaid. Regulators must do more than identify the state's health insurance grievance process; they must take steps to enable consumers and providers to challenge adverse decisions and file formal parity complaints. The process must be easy to understand so that individuals and families in crisis and providers, whose primary job is to provide treatment, will use it. It is also important that regulators accept complaints from providers that are filed formally on behalf of consumers as well as those that notify regulators of a systemic problem that could indicate a parity violation.

SIMPLE PROCESS

States should adopt a **simple method for consumers and providers to notify state regulators of potential parity violations without filing a formal complaint.** This could include a telephone hotline, which states like Maryland use for property and casualty complaints, or an email to a behavioral health email box. Many state Medicaid offices already allow concerns to be filed in this manner. This would allow regulators to compile evidence for initiating more in-depth investigations of plan compliance through a market conduct survey or examination.

Additionally, **both the process and form for submission of formal complaints must be simple and easy to understand.** State regulators should provide one on-line complaint form with clear instructions for completing and submitting the form. Enabling on-line acceptance of a formal complaint is the most consumer-friendly method, but regulators should also accept complaints via fax and mail. The process should be clearly illustrated on the insurance department or Medicaid department's website, and consumers should not be required to first file an internal appeal with the issuer or managed care organization or an external appeal. Consumers should

be made aware of the internal and external appeals process if the parity complaint stems from an adverse decision, but they should not be referred back to their insurance company to address violations. Since many parity complaints do not relate to an adverse decision, directing consumers to contact their insurance company or Medicaid plan for all parity issues will result in needless delay and will be inappropriate in some matters.

HELPFUL FORM

State insurance departments and Medicaid offices should develop a specific Parity Complaint Form with guided questions to help determine whether the facts in each case point to a potential violation. Some insurance departments use one form for all the health insurance complaints and provide a large text box to describe the issue. These forms often ask individuals to attach "relevant documents." While this format may seem like a simple process, for purposes of a parity complaint, it requires the consumer to understand much more about the legal standards than they likely will, including whether the discrimination they believe to have experienced relates to a financial requirement, a quantitative treatment limitation or a non-quantitative treatment limitation. It also requires consumers to understand how benefits are classified under the Parity Act and whether their plan's medical benefits are managed similarly in order to assert a possible violation.

An improved form would provide examples of common insurance barriers and ask specific questions such as, "What is the service you were trying to receive? What barrier did you encounter in accessing the service?" This type of form would assist consumers in filing more complete complaints and would also guide the insurance department in collecting necessary information from an insurer to investigate the complaint. A simple form dedicated to parity complaints could be very useful to consumers and providers, especially in states that do not have a health insurance ombuds office that works on parity issues. A sample parity complaint form that consumers, regulators, and consumer assistance workers can use is provided in Exhibit C.

STATE EXAMPLES

We have not identified a state that uses a parity-specific complaint form. The Maryland Insurance Administration has a specific box to check on its standard health insurance complaint form that allows a consumer to identify her problem as relating to mental health and substance use disorder parity. While other state insurance departments do not have specific parity forms or questions, their forms include questions that that could be modified to address potential parity issues. For example, some may ask if the complaint is related to a delay in accessing a covered benefit or if it is related to a denial of a service. Such questions could specifically target MH/SUD services.

ACCEPT PROVIDER COMPLAINTS

Regulators should accept complaints from providers that identify systemic problems that their patients experience. In some states, the insurance regulator requires a provider to file a complaint on behalf of a specific patient, which impedes the reporting of important information. A treatment provider is often best positioned to identify parity violations as staff routinely deal with insurers' authorization requirements, level of care denials, excluded benefits and other treatment limitations. For some parity violations, such as those involving reimbursement rate determinations and network design, providers are the only stakeholder group with knowledge of insurer practices. Regulators miss the bigger picture by requiring providers to file patient-specific complaints. Providers should be encouraged to report systemic problems via a hotline or email box and file formal complaints.

STATE EXAMPLES

Connecticut has a simple complaint process that is outlined on its website, which also includes a hotline and an online form that guides consumers through the process. The form also allows providers to file complaints with the State insurance department. The form does not, however, provide guiding questions or specifically mention the Parity Act. The New Jersey Department of Insurance has a simple online process for filing all types of insurance complaints, but it does not identify the Parity Act or behavioral health issues specifically. Pennsylvania has one process and form for all health insurance complaints with no specific MHPAEA focus. In response to advocacy from consumer organizations, the Pennsylvania Department of Insurance agreed to train some of its investigators to serve as parity experts. These experts handle the parity complaints, which advocates believe has helped consumers navigate the process and achieve improved results.

2) Provide Consumer Assistance to Explain Rights and File Complaints

States should ensure consumers have assistance in filing formal complaints. The creation of an ombuds or consumer assistance program holds the greatest promise to ensure that consumers understand their insurance and parity rights and effectively register a complaint against an insurer. For this toolkit, we use ombuds office and consumer assistance office interchangeably to mean an office or staff funded to assist individuals in accessing health care through their private or public health insurance. In states where available, this resource has increased the number of complaints and resulted in better outcomes for consumers. These offices vary in scope regarding the types of assistance provided. There are many different ways in which these offices can be established and resourced, but specific elements should be included to ensure states effectively assist consumers in accessing care regardless of the source of insurance.

Consumers need assistance with:

- Accessing timely care, including navigating the network adequacy rights afforded by state and federal laws, including the Parity Act;
- Understanding their legal rights to file an appeal under state and federal laws, including parity laws;
- Identifying the regulatory agency that has responsibility for their health plan; and
- Filing formal complaints with health plans and regulatory agencies.

An Ombuds Office must have:

- Sufficient resources to effectively assist consumers and providers, including having staff that are experts in state and federal health insurance laws, including the Parity Act;
- Broad authority to assist consumers and providers with any concern related to behavioral health access using their public or private health insurance;
- Autonomy and independence from state insurance regulators;
- Ability to refer individuals to other agencies or organizations for assistance outside their authority or expertise, including resources providing legal representation; and
- Strong relationships with behavioral health stakeholders and relevant agencies, including federal and state MHPAEA enforcement entities.

States should establish one or more ombuds offices with the authority to help individuals and providers file parity complaints at the state and federal level for private insurance and Medicaid.

STATE MODELS

The expansion of insurance coverage and new consumer protections under the Affordable Care Act prompted many states to establish, or expand, an office to assist insured consumers with insurance appeals and complaints. Additionally, some states have consumer assistance offices that assist Medicaid enrollees. Recently, some states, such as Texas, Colorado and New York have created a behavioral health ombuds program to address a wide array of behavioral health consumer concerns and complaints, including parity-related issues. These offices are tasked with assisting consumers to access mental health and substance use disorder services regardless of payer or provider. Other states, such as Connecticut and Massachusetts, have created a specific parity focus in their established health insurance consumer assistance office. Maryland advocates have worked with the Maryland consumer assistance office, the Health Education and Advocacy Unit within the Attorney General's office, to train all ombuds staff on the Parity Act.

MASSACHUSETTS

The Massachusetts ombuds office is situated in a nonprofit entity, Health Law Advocates (HLA). HLA assists individuals in filing internal and external appeals with insurers, as well as formal parity complaints. It also provides some legal representation for those individuals who meet income eligibility requirements. HLA has worked to develop strong relationships with the government agencies, including the Office of Patient Protection which is the government entity tasked with external reviews of health insurance denials. As a non-governmental legal assistance organization, HLA can assist its consumers without concern for political or bureaucratic interests. Additionally, it can set its own priorities based on the types of problems consumers identify and on-the-ground priorities. HLA is also able to conduct outreach and work to increase the number of complaints filed rather than wait for consumers and providers to initiate action.

CONNECTICUT

The Connecticut ombuds office, the Office of the Healthcare Advocate (OHA), is a government entity that was created by statute in 1999 with a broad mandate to assist all insured individuals, regardless of payer. This includes assistance with filing grievances and appeals for fully and self-funded commercial insurance as well as government funded insurance.[6] OHA also assists providers in filing complaints. While OHA was established initially in the Connecticut Department of Insurance (DOI) to leverage administrative and human resource support, it is now completely independent of the DOI. In addition, OHA has its own budget, separate from the DOI budget, which is derived from an assessment levied on the insurance carriers. This funding source

[6] CONN. GEN. STATE. ANN. § 38a-1041(2018),

provides budget autonomy and stability and contributes to the on-going independence of the agency.

TEXAS

The Texas behavioral health ombuds program, Office of the Behavioral Health Ombudsman, has been established in the Texas Department of Medicaid through the enactment of HB10 in 2017. The statute defines the ombudsman as a neutral party to help behavioral health consumers who are uninsured or have public or private health coverage. The statute also authorizes the ombuds program to assist behavioral health care providers to navigate and resolve issues related to consumer access to behavioral health care for mental health and substance use disorders.[7] The office, which is connected to the Texas Department of Health and Human Services' larger ombuds program, is authorized to assist individuals with complaints but it does not assist with internal appeals to insurers and is not able to provide legal representation to consumers. This office has been assisting behavioral health consumers with a range of health care access concerns and had begun to address Parity Act complaints, as of the date of this toolkit.

COLORADO

Colorado recently established and appropriated resources for the Office of the Ombudsman for Behavioral Health Access to Care through legislation in 2018 (HB 18-1357).[8] The office has been placed in the Behavioral Health Administration, which is intended to provide administrative and other assistance to the ombuds office. Under the legislation, the ombuds program is otherwise independent and has hiring and budget independence. The executive director of the office is a Governor-appointee. The ombuds scope of authority is broad: the office is authorized to act on behalf of consumers with private and public insurance and providers to resolve behavioral health access and coverage issues, including those related to the Parity Act.[9] Both the Texas[10] and Colorado statutes require the respective department of insurance to liaise with the ombuds office, but the ombudsperson is given the authority to provide information and assist consumers with complaints. The Colorado ombuds office is required to file an annual report to the legislature regarding the assistance provided.[11]

[7] TEX. GOV'T CODE ANN. § 531.02251 (2018).
[8] COLO. REV. STAT. ANN. § 27-80-301 (2018).
[9] COLO. REV. STAT. ANN. § 27-80-303 (2018).
[10] TEX. GOV'T CODE ANN. § 531.02251 (2018); COLO. REV. STAT. ANN. § 27-80-304 (2018).
[11] COLO. REV. STAT. ANN. § 27-80-306 (2018).

MARYLAND

Maryland's Health Education and Advocacy Unit (HEAU) is a unit of the Consumer Protection Division of the Maryland Attorney General's office. The HEAU, staffed with four ombuds staff and additional volunteers, is not specifically tasked to address parity or behavioral health issues, but assists consumers with those issues. Created in 1986, the HEAU's statutory mandate authorizes it to assist privately insured individuals in fully and self-funded plans with medical necessity and coverage decision denials in both the internal and external appeal processes.[12] While the HEAU cannot provide legal representation to consumers, it serves as a mediator between plans and consumers. For disputes that are not resolved via mediation, HEAU refers consumers to the appropriate regulating entity (state or federal) and is authorized to assist consumers with drafting formal complaint letters for an internal grievance with the plan and, if needed, an external appeal of the insurer's decision.

Under state law, all adverse decision letters must identify the HEAU as being available to assist a consumer with mediation and filing a grievance under the internal grievance process, and all grievance decisions must identify the HEAU as available to assist in filing a complaint for external review.[13] The HEAU is not authorized to assist individuals insured by Medicaid, but it has a referral mechanism to assist those individuals.

The HEAU has established strong partnerships with sister agencies, including the Maryland Insurance Administration, which directly transfers individuals who need assistance through the appeals process to the HEAU. While the ombuds staff are not marketed as parity experts, all have received training from parity experts. The HEAU will request plan disclosures as part of its assistance and will assist individuals whose insurer may have violated parity laws in drafting a letter explaining the problem to the Maryland Insurance Administration.

NEW YORK

The New York Behavioral Health Ombuds program, Community Health Access to Addiction & Mental Healthcare Project (CHAMP), is a unique private/public partnership that builds upon an existing consumer assistance program that had operated prior to the Affordable Care Act and expanded with new consumer assistance funding in 2010. The office, Community Health Advocates (CHA), is identified in the New York Model Contract grievance procedures as the independent consumer assistance program for grievances and appeals and is identified in all private insurance explanation of benefit (EOB) notices for state-regulated plans as the source of consumer assistance. Legislation enacted in 2018 created a new behavioral health ombuds function and requires the

[12] MD. CODE ANN, COM. LAW § 13-4A-02 (2018).
[13] MD. CODE ANN, INS. §§ 15-10A-02 and15-10D-02 (2018).

New York Office of Alcoholism and Substance Abuse to establish an ombudsman program. [14] The State has partnered with CHA to carry out the ombuds functions with the state's oversight.

CHA uses a hub and spoke model that engages local organizations throughout the state to address basic insurance questions and direct questions to CHA. Calls and questions that come to CHA may also be routed to appropriate partner organizations. As a nonprofit entity operating independently from New York State government, CHA represents clients in appeals and raises parity claims on behalf of insured consumers, regardless of payer. It will also consider providing legal assistance to those individuals in need of representation when an adverse decision is not resolved through the internal appeal and external review process.

ESTABLISHING A CONSUMER ASSISTANCE OFFICE

In establishing a consumer assistance office, stakeholders must determine the best way to establish, fund and maintain a comprehensive assistance program that either offers direct assistance, including legal representation as needed, to consumers, or provides a warm hand-off to a partner organization for such assistance.

The factors to consider include:

- Funding source
- Need for statutory establishment
- Scope of assistance
- Relationship to government entities

FUNDING SOURCE AND OMBUDS HOME

Stakeholders have many options for the funding and placement of an ombuds office, and each option must be assessed against the state's needs and priorities. Some consumer organizations have secured private funding to provide consumer assistance related to behavioral health issues and parity enforcement. This approach provides flexibility and greater independence from outside entities and political influence. It also allows the consumer organization to prioritize resources and use data it collects from client matters to guide other advocacy efforts. While a nonprofit approach poses a risk of funding instability, one way to secure stable funding is to establish the office through state legislation and dedicated funding. This approach would

[14] N.Y. MENTAL HYG. LAW § 33.27 (2018).

require a specific government agency to provide oversight and funds to a nonprofit entity to provide the assistance, such as New York's CHAMP.

A second approach is to secure state funding and establish the ombuds office within a state agency, such as the offices in Colorado, Texas, or Connecticut. A government entity may generate greater trust among consumers and elicit greater responsiveness from insurers, which could facilitate better accountability from insurers in insurance disputes. Another advantage to creating the office within a government agency is funding stability and the ability to leverage other government resources.

If a state decides to establish the ombuds program within a government agency, it must determine which agency is the most appropriate to house the consumer assistance and able to perform the work. Stakeholders will want to ensure that a general behavioral health ombuds office, such as the programs in Texas and Colorado, is willing to assist all consumers and providers regardless of payer (e.g., state-regulated plans, self-insured plans, or Medicaid) and that staff have insurance expertise in all payer models. Alternatively, a state could establish a payer-specific assistance program in each respective office (Medicaid and Department of Insurance) and ensure that each ombudsperson is equipped to assist with parity complaints and make appropriate referrals for persons who enter the "wrong door."

If placed within a government agency, the ombuds office must be structured so that it can operate independently of any other government entity that regulates insurance. The office budget and funding should be separate from the regulating entity. Siting the office in the insurance regulator's office may have the benefit of staff who are knowledgeable about commercial insurance, but it may also affect the ombuds staff's ability to advocate for consumers if the entity's budget is dependent on the regulator. In addition, if the ombuds office is established in a government agency, it will need to establish a referral pathway for consumers who need legal representation to resolve a dispute.

NEED FOR STATUTORY ESTABLISHMENT

States can use legislation to define the role of the ombuds office and provide a government budget and staff as Texas, Colorado, and Connecticut have done. One benefit to creating a statutorily-established behavioral health ombuds office is the ability to define the scope of the assistance to be provided. In authorizing legislation, states can also include a reporting requirement, which would help ensure resources are spent consistent with set priorities. It can also facilitate data sharing that can be used by other state entities to identify systemic problems. One disadvantage to creating an ombuds program via state statute is that it could limit the flexibility of the office to handle concerns that may not have been foreseen at the time of enactment.

SCOPE OF ASSISTANCE

In order make the best use of a consumer assistance office, states should consider developing an ombuds program with the broadest scope possible. Consumers should be able to find parity assistance regardless of payer, whether private or public. Similarly, consumers with both self and fully funded insurance plans must be able to access assistance from the same office as they likely will not know the appropriate regulatory authority. Additionally, the office should be authorized to assist providers in filing complaints.

The scope and types of assistance provided may be dependent on the home of the ombuds program. For example, if the ombuds office is sited in the insurance department, staff may not be comfortable assisting consumers and providers with Medicaid or self-funded plan parity complaints. Alternatively, locating the office in the behavioral health agency may affect whether the staff think it is appropriate to address complaints from providers as opposed to consumers. Some of the state offices considered assistance to providers within their scope while others viewed their scope as limited to working with consumers.

CONSIDERATIONS IN THE ESTABLISHMENT OF A CONSUMER ASSISTANCE OFFICE

Characteristic	Advantage	Limitation	State Example
Established in Statute	• Identifies specific scope of authority • Creates permanency • Can provide government funding source • Can require insurers to provide notice of assistance	• May allow less flexibility • May be more difficult to accomplish	New York Texas Colorado, Connecticut, Maryland (not BH or parity specific)
State Funding	• More stable than private funds • Creates a presumption of government support	• May be subject to budget cuts • May provide less flexibility and independence	New York Texas Colorado, Connecticut, Maryland (not BH or parity specific)
Sited in Government Agency	• Consumers may trust entity more • Insurers may be more responsive to entity	• May allow less independence • May allow less flexibility • Unable to provide direct legal representation • Each agency has specific expertise and a cross-payer scope will require greater expertise and more staff	Texas Colorado Connecticut

3) Improve Outreach and Education Efforts

Outreach and education about parity laws and basic insurance rights are necessary to help consumers understand their rights and available assistance.

The education process should include:

- Coordinated outreach efforts across all stakeholder groups
- Consumer friendly education materials
- Outreach and education information at critical times

COORDINATED EFFORT

State experts identify the best approach to outreach and education is a coordinated effort in which all relevant regulatory agencies and non-governmental organizations involved in enforcement and assistance develop materials and campaigns to inform consumers of their rights, how to use the complaint process, and publicize the availability of ombuds services. Consumer and provider organizations should be encouraged to help circulate information about state and federal parity laws and available enforcement assistance.

CONSUMER-FRIENDLY MATERIALS

The education and outreach campaign must offer consumer materials about basic insurance and parity rights and the consumer assistance process that are easy to understand and readily accessible.

Best practices for consumer education include:

- **Materials specifically developed for each audience,**
- **Materials made available in multiple places and accessible in areas where consumers are most likely to search for them, and**
- **All the information conveyed in plain language and easily accessible.**

The insurance department and Medicaid offices should have relevant and accurate parity information on agency websites, preferably on or adjacent to the complaint page, that explains insurance and parity rights, warning signs indicating a possible violation, and how consumers and providers can notify regulators of problems, file formal parity complaints and pursue the insurer grievance process. The US Department of Labor has a four page document that outlines some of the parity "red flags" a consumer might experience. The document, which is very text heavy, can be modified by stakeholders to address different audiences. The Parity at 10

Campaign has examples of consumer fact sheets and state education materials that can be replicated.

Additionally, consumer and provider organizations should consider developing their own materials specific to their audiences, including sample complaint letters that can be shared directly with consumers and providers. These models could be very helpful to a new ombuds office or one that is beginning to work on parity issues. The Legal Action Center has developed many letters which could serve as models.

PROVIDE INFORMATION AT CRITICAL TIMES

States should require commercial insurers and Medicaid managed care organizations to provide information about the consumer complaint process and any available consumer assistance in explanation of benefits and adverse decision letters. As states consider where to place messages and how to disseminate materials, stakeholders should identify when and where consumers are most likely to need and look for information related to parity laws. The need is often triggered by an adverse decision or coverage denial by an insurer or when a consumer cannot find a provider. In these situations, consumers must have immediate access to information about the complaint process and any assistance available to them. Other important events include when a consumer is shopping for a health plan or is reviewing their coverage documents. States should consider requiring insurers to provide information about parity laws on insurer websites and coverage documents as well.

Some states – Connecticut, Maryland, Massachusetts and New York – require insurers to identify consumer assistance services in adverse decision letters (for Medicaid) and/or explanations of benefits (EOBs) (for private insurance).[15] In those states, the ombuds office has observed that most consumers learned about their services through these notices. In states in which this notification is not required, the ombuds office struggles to get the word out about their assistance.

STATE EXAMPLES

Connecticut, Maryland, Massachusetts and New York require insurers to identify the health insurance assistance program in each adverse decision letter. This notice is the primary way that consumers in those states learn about them and are able to access their services.

[15] CONN. GEN. STAT. ANN. § 38A-591D; MD. CODE ANN, INS. §§ 15-10A-02 and15-10D-02 (2018); 211 MASS. CODE REGS. § 52.07(6)(I) (requiring notice of the Office of Patient Protection consumer assistance toll-free number and, if applicable the Massachusetts consumer assistance program); and NY Dept. of Financial Services Model Contract, Grievance, *available at* **https://www.dfs.ny.gov/insurance/health/model_lang_indx.htm**.

Maryland statute also requires insurers to provide their insured members information about the Parity Act and how to complain on their website.[16] While this is a good first step, the information would be more useful and timely if included in each EOB and adverse decision letter for mental health and substance use disorder services.

4) Require Coordinated and Specific Data Collection

State agencies should collect and report specific claims, complaint, and adverse decision data to identify potential parity violations. Improved data collection may be one of the most meaningful ways to improve the enforcement process without further burdening consumers. Because regulators often rely on the volume of complaints to assess the scope of state problems, data collection should be coordinated across state agencies and ombuds program(s). Additionally, while complaints may be one source of information about individual problems, robust and specific data collection measures and processes across the health plans' members are needed to verify and uncover systemic problems.

COORDINATED DATA COLLECTION

All states have an appeals and grievance process and a way for consumers to challenge carrier decisions that implicate parity laws. But few states collect specific parity complaint or adverse decision data and fewer coordinate data collection across agencies that could use the information for oversight. Each agency that assists with appeals or enforcement actions often collects its own complaint and resolution data separately, and the data are not aggregated across the agencies. In some states, where there are multiple enforcement agencies and ombuds programs, stakeholders report that multiple agencies and organizations collect separate data with little crossover in elements or reporting requirements. We were not able to find any state examples of well-coordinated data collection efforts.

SPECIFIC DATA ELEMENTS

States should require carriers to report adverse decisions and other coverage decisions in a format that will help regulators identify potential parity problems. It is not enough to collect raw numbers of adverse decisions and outcomes of appeals. The data must be sorted into the relevant Parity Act classifications of benefits and related to specific non-quantitative treatment limitations. For example, carriers should report the number of adverse decisions, grievances and reversals, and external review complaints and outcomes for mental health/ substance use disorders and medical/surgical care by the six classifications of benefits. These data should be reported by each carrier and should be supported by claims data. Consumer assistance staff and review agencies should similarly track complaints and questions in the same manner. All

[16] MD. CODE ANN, INS. §15-802(e) (2018).

the data should then be aggregated by the enforcement entity and used to determine where additional enforcement action may be needed.

STATE EXAMPLES

In 2017, Texas established a parity-specific data collection requirement for complaints and NQTLs in legislation (HB 10) that required the state agencies that regulate commercial plans and Medicaid to collect and compare data from issuers for medical/surgical, mental health and substance use disorder benefits for a single year. The data included:

- Benefits subject to prior authorization or utilization review, including step therapy;
- Denials based on medical necessity or experimental/investigational exclusions; and
- Appeals and outcomes for internal appeals and external reviews.

The Texas Department of Insurance published a twelve-page document providing instructions to plans to guide data reporting. Issuers were required to provide information supported by claims data in the six classifications of benefits for all three benefit types. Additionally, plans were required to report specific utilization review data that illustrated the "in operation" non-quantitative treatment limitation requirement. [17] Medicaid MCOs were required to report similar data. The September 2018 report, submitted by the Texas Department of Insurance, may serve as a model for other states. Because many insurers do business in multiple states, they should not find the process burdensome if states require similar reporting.

Other states have established annual data reporting requirements targeted at Parity Act enforcement. For example, Connecticut,[18] Massachusetts,[19] and Vermont[20] have annual reporting requirements for private health plans, and New Hampshire[21] and Tennessee[22] have data reporting requirements for Medicaid managed care organizations.

[17] House Bill 10 Data Collection, Instructions for Reporting- Revised April 19, 2018. Document on file at Legal Action Center.
[18] Conn. Dept. of Insurance, "Consumer Report Card on Health Insurance Carriers in Connecticut," Oct. 2018, *available at* **https://www.ct.gov/cid/lib/cid/2018-ConsumerReportCard.pdf**.
[19] Massachusetts Office of Consumer Affairs and Business Regulation, Div. of Insurance, Bulletin 2013-06 Regarding Disclosure and Compliance Requirements for Carriers, and Process for Handling Complaints for Non-Compliance with Federal and State Mental Health and Substance Use Disorder Parity Laws (May 31, 2013), at pp. 3-4, *available at* **https://www.mass.gov/files/documents/2017/11/22/Bulletin%202013-06%20%28Mental%20Health%20Parity%29.pdf**.
[20] VT. ADMIN. CODE § 4-5-7:5 (Regulation 2000-03-H).
[21] New Hampshire Dept. of Health and Human Services, Medicaid Services, "Mental Health and Substance Use Disorder Parity,"(Oct. 2, 2107), App. D at 14, *available at* **https://www.dhhs.nh.gov/ombp/medicaid/documents/parity-analysis-100217.pdf**.
[22] TENN. CODE ANN. § 71-5-154 (2018).

Implementation

Building Relationships and Finding Champions

Consumer and provider organizations should work to build strong relationships and develop parity champions in government agencies. Implementation of each best practice requires coordination between state regulators, consumer assistance entities and non-governmental consumer and provider organizations. Developing good relationships with regulators and consumer assistance programs is required for any consumer and provider organization. With strong relationships, a feedback loop can be established that informs agencies about on-the-ground problems and how their process can be improved.

Creating strong relationships with regulators also helps to educate and develop parity champions within the regulating entity and in other state offices. Some state insurance departments focus on the solvency of the insurance market and rate stabilization, placing less emphasis on key consumer protections that are equally important to consumers. Consumer representatives in some states have worked hard to build relationships with insurance regulators to ensure that strong consumer protections are a core tenet of the agency. As a result, those offices are more approachable for consumers needing assistance.

While each of these best practices is critical for a model consumer complaint process, it may not be feasible to address all in one initiative. ***Stakeholders must determine the most feasible area(s) for improvement in the context of the state's political and budgetary climate, the area(s) in need of the most improvement, and the area, if improved, that would have the greatest impact on consumers.*** We recommend considering political and budgetary factors and developing a feasible timeline for the adoption of the best practices.

Assess and Develop a Plan

To implement a plan to improve your state's Parity Complaint Process, consider the following steps and guiding questions.

1. **Assess your state's informal and formal complaint processes.**
    - Does your state have an informal health insurance complaint process, such as a hotline or email box?
    - Is the current process simple and available for both consumers and providers?
    - Does the public know about the complaint process? How are consumers informed about their parity rights, and is more outreach and education necessary? Is information about the process posted on both the insurance department and Medicaid Department websites?

- Does your state have an ombuds office to assist consumers and providers with insurance questions and concerns? If so, does it offer assistance with parity specific complaints?
- Do state agencies collect and report complaint and adverse decision data that are needed to evaluate disparities in the delivery of mental health and substance use disorder benefits? If so, are the data collection efforts coordinated?

2. **Assess your state's budget and readiness for improvement.**
    - Are state agencies interested in working with stakeholders to improve their complaint processes, education initiatives, and data collection?
    - Will legislative and executive branch officials support efforts to improve the process?
    - Are state officials and decision makers engaged in other initiatives to improve access to mental health and substance use disorder treatment, and how would a consumer awareness and complaint process supplement those efforts?
    - Which of the best practices is most timely for legislators or other decision-makers? Can stakeholders lay the ground work to establish an ombuds office over a multi-year effort?
3. **Partner with other stakeholders.**
    - Identify other health focused groups that are interested in improving the commercial insurance and Medicaid complaint process and build support for the establishment of a consumer assistance office.
4. **Develop a plan to improve the process.**
    - Identify the sequence for implementing improvements and a timeline for adoption based on gaps, resources and greatest impact for improvement.
    - Determine available resources (time, money, staff) that all stakeholders can allocate to this project.
    - Identify how this initiative fits into and advances other parity priorities.

Conclusion

To improve parity compliance, state stakeholders, including consumers, health providers and state insurance and Medicaid regulators, should invest in the development and implementation of a comprehensive Parity Complaint Process. This effort will meet the needs of all parties whose goal is to maximize insurance coverage and reimbursement for mental health and substance use disorder services. A comprehensive complaint process will offer essential direct assistance to consumers so that they may effectively challenge unlawful denials of care by their health plan, and the data derived from consumer complaints will inform regulators and other state policymakers about systemic violations. The Parity Complaint Process should include education for consumers and providers about insurance standards and parity protections; the implementation of an informal complaint notification process to state regulators along with a formal parity complaint process that is separate from the grievance and appeal process; and the creation of a behavioral health ombuds program. While State regulators should not rely on a complaint-centric process as the primary parity enforcement strategy, the complaint system is an important tool that should help consumers get the mental health and substance use disorder services they are entitled to receive through their health plans.

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http://parityat10.org

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Exhibit A

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Exhibit B

Summary of Best Practice Recommendations

Implement a Simple, Inclusive, Consumer-Friendly Complaint Process

I. Create an easy to navigate complaint process for consumers and providers.
II. Establish a hotline or email box for consumers and providers to identify problems without filing a formal complaint.
III. Create a simple complaint form with specific parity questions.

Provide Consumer Assistance to Explain Rights and File Complaints

I. Establish a Parity or behavioral health ombuds office that is well-resourced and has a broad scope to assist providers and consumers with coverage in all insurance markets.

Improve Outreach and Education Efforts

I. Coordinate education and outreach efforts with all stakeholder organizations.
II. Create consumer friendly materials and timely messages.
III. Require insurers to provide consumer assistance information and Parity Act information in adverse decision letters and explanation of benefits (EOB) notices.

Require Coordinated and Specific Data Collection

I. Establish specific parity complaint-related data collection requirements.
II. Coordinate data collection across all state agencies and external ombuds offices.

Implementation

I. Strengthen relationships with and cultivate regulatory champions.
II. Assess state's current complaint process and develop a plan for improvement.

Exhibit C

Sample Mental Health and Addiction Parity Complaint Form

Please answer all questions that apply to your complaint. Please sign the attached consent form so that we can investigate your complaint. Send all materials to: [email and mailing address].

Date _____

Name of person completing form _____

Contact information

Address_____

City, State, ZIP _____

Phone _____ Email _____ Preferred method of contact _____

Are you the (check all that apply): Patient ☐ Provider ☐ Patient Representative ☐ Insured ☐

Patient Name _____

Name of Insurance Company or Medicaid Managed Care Organization (Name listed on your insurance card). _____

Policy Number _____ (Number listed on your insurance card)

How do you get your insurance?

Employer (name of employer): _____

Self-purchase (individual or family) ☐ Medicaid ☐ Medicare ☐

Other ☐ Don't know ☐

Briefly describe your complaint

Is your complaint related to: Mental Health ☐ Substance Use Disorder ☐ Both ☐

Please identify the type of treatment involved in this complaint (check all that apply):

Inpatient ☐ Outpatient ☐ Emergency Care ☐ Prescription Drugs ☐

Date of the problem (month, day, year): _____

Is this related to a denial of treatment? Yes ☐ No ☐

If yes, have you filed an appeal with your insurance company or Medicaid Managed Care Organization? Yes ____ No ____

If yes, has a decision been made on your appeal? Yes ____ No ____ I don't know ____

If yes, what was the result of the appeal?

Do you believe your insurance company or Medicaid Managed Care Organization may have violated the Mental Health Parity and Addiction Equity Act? This law prohibits health insurance discrimination against individuals with mental health and substance use disorders.

Yes ____ No ____ I don't know ____

Did you have trouble getting treatment due to any of the following items? (Check all that apply and give a brief description of the problem in the box.)

____ Unable to find a provider in my network of providers.

____ Authorization process delayed my treatment.

____ One type of treatment was requested, but my health plan approved a different service.

____ Prescribed or requested treatment or medication was excluded from coverage.

____ Required to fail at a lower level of treatment before the health plan would authorize the prescribed or requested treatment.

☐ Treatment facility or provider wasn't covered due to geographic or other restrictions.

☐ There is a limit on number of visits or days.

☐ Other

Did you experience other barriers or problems? (Check all that apply and give a brief description of the problem in the box.)

☐ The allowed amount or amount reimbursed was much less than expected.

☐ Insurer would not provide requested information about my health benefits or its treatment decision.

☐ Other Problems

Please include/attach any supporting documents, including any letters or notices from your insurance company or Medicaid Managed Care Organization.

If you have questions, please contact: [contact name and number]