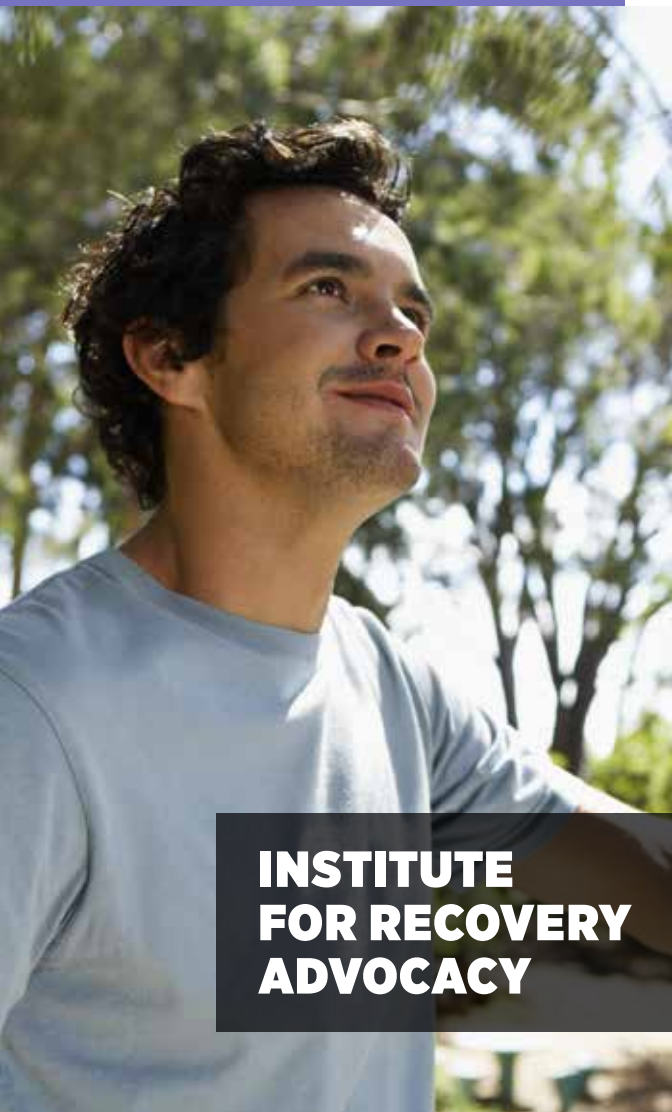
Hazelden Betty Ford
Institute for Recovery Advocacy

Coverage for Addiction and Mental Illness: *Now It Is the Law*

How to be your best advocate when working with your health insurance company



HBFinstitute.org
800-257-7800

Get the answers you need to questions about your addiction treatment.

Hope starts with help

In 2010, millions of people and their families who needed help for addiction to alcohol or other drugs gained a new resource: health insurance. A federal parity law expanded access to treatment by prohibiting most insurance plans from restricting coverage or imposing unequal limitations on treatment options. Even though insurers and employers are aware of this new law and their required compliance, it is up to you, the consumer, to make sure you or your loved ones receive the resources for treatment you need and deserve. Know your rights. Don't be afraid to stand up and speak out for the benefits required under the law.

Ask questions. Get clarification. Negotiating with your insurance provider can be stressful and difficult. Don't give up.

Who you need to contact

- Call Member Services at your insurance company.
- Have your membership identification ready.
- Write down the name of the Member Services representative who talks with you.
- Take notes of your conversation.
- If you have employer-sponsored coverage, advise your human resources professional that the plan appears to be noncompliant.

Questions you need to ask

- What "levels of care" are covered for addiction treatment? (Examples of levels of care include: inpatient, outpatient, residential, hospital-based, and partial hospitalization.)
- Please clarify which in-network and out-of-network behavioral health and medical providers I have access to. And, what percentage of behavioral health and what percentage of medical benefits does my plan cover?
- What is my out-of-pocket maximum expense?
- What criteria do you use to determine medical necessity?

Quick answers to key questions about expanded coverage

What are the new law's basic requirements?

Employer-sponsored group health plans can no longer discriminate in their coverage of addiction and mental health benefits. If they do, they must have financial requirements and treatment limitations that are no more restrictive than those placed on medical or surgical benefits. This applies to out-of-pocket expenses, copayments and deductibles, as well as medical management criteria related to "medical necessity," "prior authorization," "concurrent review," and "utilization review."

Are there exceptions?

Grandfathered small group plans that were in existence before March 23, 2010, are exempt; otherwise, small group plans must now comply. Also, the new federal law protects any stronger state laws mandating coverage for addiction and mental health treatment.

What happens if I seek treatment resources that are not within my plan's network?

Choosing to go out-of-network no longer means you are out of luck. An insurer that provides benefits for addiction and mental illness treatment and that provides out-of-network coverage for medical/surgical benefits must provide *equal* out-of-network coverage for addiction and mental illness treatment.

Does the law apply to other health plans?

Yes. In addition to group health plans and insurers, Medicaid-managed care plans and state children's health insurance programs are included. Plans sold under the insurance "exchanges" of the Affordable Care Act (ACA) are also covered by parity, and they must provide addiction coverage as an "essential benefit."

What can I do if I am denied treatment or my options are restricted?

The new law requires that the insurer must, upon request, provide you with the reason for the denial. If the plan says service was not "medically necessary," you are entitled to request and receive the plan's medical necessity criteria specific to mental health and addiction treatment coverage. Visit the Parity Implementation Coalition (**ParityIsPersonal.org**) for more information.

Glossary of Terms

Affordable Care Act The federal law that expands access to health insurance. One of the "essential health benefits" under the law is addiction coverage.

Coinsurance An amount an individual may pay for services after a deductible has been paid. Coinsurance is usually a percentage of what the health care provider will receive for the services. For example, the individual pays 20 percent of the charges for a service and the insurer pays 80 percent.

Copayment A predetermined flat fee an individual pays for health care services, after a deductible has been paid and in addition to what the plan or insurer pays. For example, some plans may require a $50 copayment for each office visit.

Day Limit Maximum number of days of coverage available through your insurer.

Deductible The amount an individual must pay for health care expenses before an insurer covers the costs. Often, coverage includes yearly individual and family deductible amounts.

Denial of Claim Refusal by an insurer to cover an individual's health care services.

Explanation of Benefits (EOB) An insurer's written explanation to a claim, showing what they

Don't be intimidated by the tangle of terms and conditions when trying to use your health care coverage. Ask for clarification when you don't understand. Get the answers you need.

paid and what the client must pay. If the claim is partially or wholly denied, the EOB will describe a process for appeal. Grandfathered plans, or those that were in place before March 23, 2010, may be exempt from the ACA and Mental Health Parity and Addiction Equality Act requirements.

In-Network Providers Physicians, hospitals, and other health care providers that have contracts with an insurer to provide services to its members, usually at discounted rates. Individuals with coverage usually pay less when using in-network providers because of those negotiated discounts.

Inpatient Health care services provided on an inpatient basis, meaning the individual stays overnight at an inpatient facility, typically a hospital.

Maximum Dollar Limit The maximum amount an insurer will pay for claims within a specific time period.

Medical Necessity Criteria used by insurers or their review agencies to determine coverage for various levels of care. Each reviewer may use a different set of criteria. One common set of criteria for mental health and addiction treatment coverage determinations comes from the American Society of Addiction Medicine (**ASAM.org**).

Out-of-Plan/Out-of-Network Physicians, hospitals, and other health care providers that are not contracted with the plan or insurer to provide health care services at discounted rates. Depending on an individual's plan, expenses incurred by services provided by out-of-plan health care professionals may not be covered or may be only partially covered.

Out-of-Pocket Limit A predetermined amount that an individual must pay before the plan or insurer will pay 100 percent for an individual's health care expenses. Out-of-pocket limits are usually applied on a yearly basis.

Outpatient Health care services provided on an outpatient basis, meaning the individual does not stay overnight at an inpatient facility, such as a hospital.

Parity The Mental Health Parity and Addiction Equality Act of 2008, which is a federal law designed to protect mental health and/or substance use coverage benefits.

Precertification An insurer's review of an individual's health care status or condition that usually occurs prior to an individual being admitted to an inpatient facility, such as a treatment center. Precertification is part of determining health care coverage and might involve meeting medical necessity criteria.

Preexisting Condition A coverage limitation that may apply when an individual's health care coverage changes, as from one insurer to another or one employer to another. The limitation states that certain physical or mental health conditions, either previously diagnosed or that would normally be expected to require treatment prior to coverage under the new policy, will not be covered under the new policy.

Reasonable & Customary Fees/Usual & Customary Fees (U&C) The average fee charged by a particular type of health care practitioner within a geographic area. These fees are often used by insurers to determine the amount of coverage for health care provided by out-of-network providers. The individual may be responsible for any copayment, coinsurance and deductible, as well as any remaining portion of the provider's fee that is not covered by the Reasonable & Customary Fee.

Residential Health care services such as chemical dependency treatment in a residential setting that is not hospital based but is, rather, a freestanding facility.

My Notes

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Our mission is to provide a leading national voice on all issues related to addiction prevention, treatment and recovery and to facilitate conversation among those in recovery, those still suffering and society at large. We are committed to smashing stigma, shaping public policy and educating people everywhere about the problems of addiction and the promise of recovery.

The Hazelden Betty Ford Institute for Recovery Advocacy is part of the Hazelden Betty Ford Foundation, the nation's largest nonprofit treatment provider. With a legacy that began in 1949 and includes the 1982 founding of the Betty Ford Center, the Foundation has 16 sites in California, Minnesota, Oregon, Illinois, New York, Florida, Massachusetts, Colorado and Texas.

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