



Psychotherapy Action Network

## AUSTEN RIGGS CENTER

### **INSURANCE AND PARITY ADVOCACY TOOLKIT**

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## CURRENT ENVIRONMENT – LEGAL AND LEGISLATIVE ISSUES

### Overview of landmark class action *Wit v UBH* case

The federal class action lawsuit, known as *Wit v United Behavioral Health (UBH)*, resulted in a landmark victory for the plaintiffs. This class action suit was brought on behalf of patients who had UBH insurance policies, but were denied coverage by UBH for residential, substance use disorder, and outpatient treatment. In February of 2019, Chief Magistrate Judge Joseph Spero of the United States District Court for the Northern District of California released his sharp and detailed rebuke of UBH for putting profits before people from 2011-2017 across four states: Connecticut, Illinois, Rhode Island and Texas. In the written opinion, Judge Spero stated that “the Court finds, by a preponderance of the evidence, that UBH has breached its fiduciary duty by violating its duty of loyalty, its duty of due care and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care,” and further, that “by a preponderance of the evidence, that UBH’s Guidelines were unreasonable and an abuse of discretion because they were more restrictive than generally accepted standards of care.”

In addition, the court’s decision highlighted the financial self-interest associated with utilizing medical necessity criteria that do not follow generally accepted standards of care. Stunningly, the UBH guidelines were found to be heavily influenced by the insurance company’s finance department. Also, while Judge Spero found the plaintiffs’ experts credible, he characterized UBH’s medical experts as having “serious credibility problems” related to the extent their testimony was marked by evasiveness and, in some cases, deception.

In the Remedy phase, Judge Spero ordered UBH to reprocess 67,000 claims using multidimensional access to care criteria developed by nonprofit professional organizations (LOCUS, ASAM Criteria), imposed a 10-year injunction on UBH, and appointed a Special Master to train UBH staff in their fiduciary duty to patients and in the generally accepted standards of care.

Unfortunately, this case hit a strange roadblock in 2022 when a subset of judges from the Ninth Circuit Court unexpectedly overturned the entire ruling on appeal. The plaintiffs’ lawyers have requested that this short, 7-page decision receive an *en banc* review, which would include all 29 members of the Ninth Circuit. The plaintiffs were supported by amicus briefs by a number of groups, including the American Psychological Association, the Illinois Attorney General and others.

## Generally Accepted Standards of Care

Generally accepted standards of care are those standards which are based on credible scientific evidence and generally recognized by mental health experts.

### Sources of Generally Accepted Standards of Care

Some sources of generally accepted standards of care from non-profit clinical specialty organizations include the following:

- American Society of Addiction Medicine [ASAM Criteria](#)<sup>®</sup>
- American Association for Community Psychiatry [LOCUS FT](#)
- American Academy of Child & Adolescent Psychiatry [CALOCUS-CASII](#)
- Centers for Medicare & Medicaid Services (CMS) [Medicare Benefit Policy Manual](#)
- American Psychiatric Association [Practice Guideline for the Treatment of Patients with Substance Use Disorder, 2<sup>nd</sup> Ed](#)
- American Psychiatric Association [Practice Guideline for the Treatment of Patients with Major Depressive Disorder 3<sup>rd</sup> Ed](#)
- American Academy of Child & Adolescent Psychiatry [Principles of Care for Treatment of Children and Adolescents with mental Illnesses in Residential Treatment Centers](#)

In his 106-page verdict, Judge Spero carefully reviewed standards of care as defined by nationally recognized organizations and medical experts. In each instance, Judge Spero found that UBH's guidelines for coverage were inconsistent with generally accepted standards, for example, because they focused excessively on treatment of acute symptoms rather than either long-term improvement or prevention of deterioration and maintenance of existing function, and because they judged children's needs according to adult criteria.

Based on his review of the published guidelines, Judge Spero identified eight principles of effective treatment that reflect generally accepted standards of care.

### Eight Principles of Effective Treatment That Reflect Generally Accepted Standards of Care

- 1) Effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms.
- 2) Effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care
- 3) Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective
- 4) When there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care

- 5) Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration
- 6) The appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment
- 7) The unique needs of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders
- 8) The determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient

#### Standards of care, in brief

- 1) Treat the **underlying condition**, not only current symptoms
- 2) Treat **co-occurring** conditions (including mental health, substance use and medical)
- 3) Treat at the least intensive level of care that is **safe** and **effective**
- 4) Err on the side of **caution**
- 5) Effective treatment includes services to **improve functioning**, maintain day-to-day functioning, and to **prevent deterioration**
- 6) Determine **duration** of treatment based on individual needs
- 7) Take unique needs of **children / adolescents** into account
- 8) Make level-of-care decisions based on a **multidimensional assessment**

## **Parity between mental health and physical health insurance coverage**

Under state and federal mental health parity laws, health insurance companies/plans are required to provide treatment for mental/behavioral disorders and substance abuse equitable (on “par”) to physical illnesses or injuries. In short, insurance plans cannot discriminate against someone because they have a mental health or substance use disorder.

### Defining Parity

The following points outline what patients and clinicians are entitled to, under the federal “Mental Health Parity” law:

- 1) Patients are entitled to the treatment that their clinician says is necessary for their mental health or substance use disorder. The insurance plan cannot require that the patient “fail first” at less expensive treatments, if it does not have the same “fail first” requirements on most other illnesses covered by the plan.
- 2) With few exceptions, the co-pay or co-insurance for mental health benefits should not be higher than it is for other medical care, and there should only be one deductible and out-of-pocket maximum that covers all health care treatment.
- 3) If a patient visits a psychiatrist both for medication management and for psychotherapy on the same day, they should only pay one co-pay.
- 4) Patients should have access to an “in network” mental health provider who is qualified to treat their condition and can see them in a reasonable amount of time at a location accessible from their home.
- 5) Mental health appointments or treatment should not require pre-authorization, unless the insurance plan requires pre-authorization for most other medical care.
- 6) The number of appointments/visits or hospital days should not be limited, unless there are similar limitations for most other medical illnesses under the plan.
- 7) The health plan should pay even if the recommended course of treatment is not completed.
- 8) The health plan is required to provide the patient with a written explanation of:
  - a) How it evaluated the need for treatment
  - b) Why it denied the claim
  - c) The basis for its conclusions that the plan complies with federal law
- 9) Patients have the right to appeal the plan’s decisions about care or coverage. Patients have the right to appeal the claim with the plan and with an independent review organization (check the state insurance commissioner’s office)
- 10) If the plan has out-of-network benefits and a patient sees an out-of-network clinician, and the amount reimbursed is significantly less than the amount the plan pays to other doctors who are out-of-network, this may be illegal. The Explanation of Benefits (EOB) should indicate how much clinicians are paid.

Source: [\*American Psychiatric Association\*](#)

## Examples of Parity Violations

Below are five common “parity” violations.

- Excessive or different co-payment or co-insurance:
  - If a health plan charges different co-pay or co-insurance amounts for mental/behavioral health services than those charged for similar level of medical services, this is likely a federal parity law violation.
- Withholding authorization, treatment or payment due to Fail-first policies:
  - If a health plan withholds authorization, denies care, or denies payment for mental or behavioral services because the member has not yet tried and failed at a lower level of care, this is likely a federal parity law violation.
- Limiting the quantity or frequency of mental health treatment:
  - If a health plan limits the number of visits one has for mental health (i.e. yearly or lifetime visits) or how often one can visit a clinician, particularly if different than one’s access for physical treatments, this is likely a federal parity law violation.
- Imposing more restrictive prior authorization (IR) policies for mental and/or behavioral health treatment:
  - If a health plan requires prior authorization for any level of service that is not required for a similar physical treatment or requires greater clinical detail (either for admit criteria or treatment planning)
- Imposing excessive concurrent review (UR) policies for mental and/or behavioral health treatment:
  - If a health plan requires ongoing “medically necessity” reviews with one’s therapist to justify continued treatment, and this requirement is too frequent, overly burdensome, or does not conform to the plans stated guidelines, it is likely a violation of federal parity law.

Source: <https://www.parityregistry.org/parity-violation-examples/>

For instructions on how to deal with parity violations and file appeals, see section “Dealing with Denials, Complaints and Appeals.”

## **New state laws protecting patients and parity**

The Mental Health Parity and Addiction Equity Act of 2008 ushered in the first sweeping national legal mandate for parity for mental health treatment benefits. The 2010 Affordable Care and Patient Protection Act strengthened parity, by naming mental health care, including psychotherapy, as an Essential Health Benefit. Unfortunately, many insurers are still not fully in compliance with the law, and insurers commit many violations—through practices around prior authorization for services, inadequate provider networks, and unfair reimbursement, among others.

To move towards real parity, new legislation incorporates key aspects of the *Wit v UBH* ruling, and adds new requirements for insurers. These new state laws usher in an era of accountability for commercial health insurers and set the stage for national reform.

Judge Spero's decision brings the law to bear on a set of circumstances under which insurance companies illegally deny care, particularly of the treatment of underlying conditions. It also opens the door to one important part of a solution: his explicit inclusion of generally accepted standards of care in his findings serves as a template for new state legislation that requires medical necessity determinations, and the criteria used to make these determinations, be consistent with these standards. Such legislation can have a significant impact on the scourge of undertreatment and its profound human and societal costs, going a long way towards protecting parity, respecting clinicians' treatment decisions, and providing patients with clear legal support for actually receiving the insurance benefits they've paid for.

### California - [Senate Bill 855 \(SB855\)](#)

In September, 2020, California Governor Gavin Newsom signed SB855, making California a national leader in mental health and addiction parity.

- expands parity protections and requires insurers to pay for medically necessary treatment for all conditions described in the DSM, rather than to just nine previously identified mental health disorders
- establishes a state-wide definition of “medical necessity,” and requires insurers to make benefit determinations that are consistent with “generally accepted standards of care” from the landmark *Wit* decision
- requires insurers to exclusively apply medical necessity criteria developed by non-profit clinical specialty associations.
- expressly forbids insurers from limiting benefits or coverage for mental health and substance use disorders to short-term or acute treatment

### Illinois - [House Bill 2595, “Health is Health”](#)

In August, 2021, Illinois Governor J. B. Pritzker signed HB2595, requiring medically necessary mental healthcare to be covered by insurance beginning January 1, 2023.

- incorporates key components of the California bill, including medical necessity criteria and mandate to use criteria and guidelines developed by non-profit clinical speciality associations
- requires insurance companies to maintain an adequate network of mental health care providers and provide their beneficiaries with timely and convenient access to mental health treatment
- people will not have to wait more than 10 business days to see a provider after requesting an initial appointment or 20 business days after requesting a repeat or follow-up appointment
- in the Chicago area, people will not have to travel more than 30 miles or 30 minutes from their home to see a provider. In other areas of Illinois, the limit expands to 60 miles or 60 minutes
- requires insurers to cover out-of-network copays, if no in-network providers are available within those time and distance limits

Oregon - [House Bill 3046 \(HB3046\)](#)

In Summer 2021, Oregon became the third state to successfully pass medical necessity criteria legislation.

- requires that managed care organizations use criteria and guidelines developed by non-profit clinical specialty association when determining the type, duration and intensity of care covered for patients
- requires detailed annual reporting addressing requirements, including how insurers reimburse for mental health services
- Requires insurers and coordinated care organization to follow generally accepted standards of care (in large part based on the *Wit vs. United* case) which addresses proper levels of care and the need to treat co-occurring behavioral health conditions among other coverage principles
- ensures that insurer networks are providing sufficient access to a range of professionals, which includes factoring the patient's age, language, culture and complex behavior health conditions

Georgia - [House Bill 1013 \(HB1013\)](#)

The Georgia bill includes the following:

- creates a new definition for "generally accepted standards of mental health or substance use disorder care" and defines it as independent standards of care and clinical practice recognized by certain specialty health care providers, including psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment.
- Additionally, the definition specifies valid, evidence-based sources of accepted standards of mental health or substance use disorder care. The definition of "medical necessity," "medically-necessary care," or "medically necessary and appropriate" is also



revised to include behavioral health services that screen, prevent, diagnose, manage, or treat an illness.

- health care insurance plans that provide coverage for mental health treatment or substance use disorders do so in accordance with the federal 'Mental Health Parity and Addiction Equity Act of 2008.'
- Health insurers must also provide an annual comparative analysis report to the insurance commissioner, which will be available on the Office of the Commissioner of Insurance and Safety Fire's (OCI) website.

### Model Legislation for other states

The Kennedy Forum developed the [Jim Ramstad Model State Parity Legislation](#), which serves as a template or model for other states to enact legislation. The model bill holds health insurers accountable for discriminating against those with mental health and substance use disorders by wrongly denying coverage of care. PsiAN was one of the many mental health organizations supporting this model legislation.

Jim Ramstad served in the U.S. House of Representatives from 1991-2009, representing Minnesota's 3rd congressional district. He joined former Democratic Rep. Patrick J. Kennedy as the lead Republican cosponsor of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires insurers to cover treatment for mental health and substance use disorders no more restrictively than treatment for illnesses of the body, such as diabetes and cancer.

The new model bill named for Rep. Ramstad, who passed away in November, 2022, is based off of California's groundbreaking new law, Senate Bill (SB) 855. Key elements include requiring that all insurers follow generally accepted standards of behavioral health care when making medical necessity decisions, and using criteria from non-profit clinical specialty organizations (as opposed to the insurance company's own criteria).

## ADVOCATING WITH THE PUBLIC

Here are some examples of using the national media to advocate and educate.

### National media – New York Times

In August 2021, the New York Times published an influential article documenting the serious problem of parity loopholes and the harmful impacts on patients and access to mental healthcare. The article, [Teachers, Police, and Other Public Workers Left Out of Mental Health Coverage](#), focused on the City of Chicago, one of the largest entities that takes advantage of the loophole. This has been a longstanding problem, where any non-federal governmental entity--city governments, police and fire departments, state colleges and universities--could choose *not to offer* mental health coverage in their insurance plans. Thus, this loophole allows these entities to opt out of complying with the 2008 Parity Act - and those who work for these government bodies or universities may not have equitable mental health insurance coverage.

PsiAN chair and co-founder **Linda Michaels** is quoted throughout the article and a former patient of hers who had insurance through the City also agreed to be interviewed. Journalists place a high priority on including a patient's perspectives. Of course, therapist and patient should address any ethical concerns or potential impact on the therapeutic relationship if the therapy is ongoing prior to engaging with the media.

In addition to this and other articles in the media, powerful and sustained advocacy by organizations such as Kennedy Forum contributed to key legislation passed by the U.S. Senate in December, 2022, closing the loophole. Governmental entities are no longer able to opt out of complying with the Mental Health Parity and Addiction Act requirements. You can learn more about this legislative victory [here](#).

### Getting creative with media – John Oliver

Reaching the public and explaining complex issues can also be done with a sense of humor. In July 2022, the hit HBO show, Last Week Tonight with John Oliver, took on the thorny and complex issues of mental healthcare. From apps posing as therapy, to insurance companies' ghost networks, to lack of real parity, to a systemic focus on crisis management as opposed to healing and recovery thus violating generally accepted standards of care, Oliver makes smart, insightful, cogent points - and many a good joke.

To create the show, Oliver's **producers interviewed PsiAN's Chair and Co-Founder, Linda Michaels, two PsiAN Advisors, Meiram Bendat and Hannah Zeavin, and our friend and Chief Policy Officer at the Kennedy Forum, David Lloyd.**

Watch the show here: [Last Week Tonight - Mental Health - 7.31.22 show](#).

## DEALING WITH DENIALS, COMPLAINTS AND APPEALS

### Instructions for filing parity complaints

If you believe there has been a parity violation, here is how to file a complaint:

Step 1: Identify type of insurance coverage from the list below	Step 2: Complete complaint letter using the templates	Step 3: Submit to the responsible agency
Insurance plans (plans purchased by employers, or by individuals)	<a href="#">Template complaint letter to state insurance commissioner</a>	State insurance commissioner
Employer pays for coverage (Self-funded plan)	<a href="#">Template complaint letter to Department of Labor</a>	U.S. Department of Labor
Insurance through state/local government employers	<a href="#">Template complaint letter to Department of Health and Human Service</a>	U.S. Department of Health and Human Services

Source: [American Psychiatric Association](#)

## Sample templates of appeal and medical necessity letters

The [Austen Riggs](#) Center offers medical necessity and appeal letter templates to support clinician and patient efforts to secure insurance coverage for medically necessary behavioral health treatment. These resources are grounded in principles of effective treatment that reflect generally accepted standards of care within the behavioral health and psychiatric medical community. Additional resources and sample letters are listed in the Resources section at the end of this document.

In 2021, the article “[Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients](#)” explains the value of providing a “medical necessity letter” to help patients secure insurance coverage. The authors recommend that all clinicians draft such a letter to each patient’s file, so that the necessity of providing treatment is clearly delineated.

The authors outline 4 key elements in an effective medical necessity letter:

1. A statement of provider credentials;
2. A description of your practice, including level of experience and expertise in treating people with specific mental and substance use disorders;
3. A clinical assessment of the patient, especially unique aspects of the patient’s presentation, history, or living circumstances; and
4. Most importantly, an explanation as to why the course of treatment is “medically necessary,” including the rationale (clinical decision-making process) justifying that treatment.

While we await the Ninth Circuit Court’s response, here is a [revised version](#) of the medical necessity letter.

### Letters of Medical Necessity for Different Levels of Care

For [outpatient psychotherapy services](#), this template offers language that may assist in writing a medical necessity letter to help patients secure insurance coverage.

For [residential treatment](#), this template offers language that may assist in writing a medical necessity letter to help patients secure insurance coverage.

## RESOURCES

Here are links to two comprehensive guides that outline the background, relevant issues, processes and templates for filing appeals of insurance company coverage denials, and more.

### [Kennedy Forum-NAMI Appeals Guide](#)

The Guide's eight sections include general background and terminology pertaining to health insurance plans; detailed overviews of the clinical and administrative appeals processes; information about the 2008 Mental Health Parity and Addiction Equity Act (Federal Parity Law); best practices for filing an appeal letter; and frequently asked questions.

### [National Council on Behavioral Health - toolkit](#)

The National Council for Mental Wellbeing developed a toolkit to empower mental health and substance use disorder clinicians and organizations to claim their role as the expert authority on generally accepted standards of care. This toolkit provides a compelling argument for upholding generally accepted standards of care and practical tools for implementing an effective appeal strategy, including appeal letter templates and insurance claim review talking points.

### [“Eight Principles of Effective Treatment That Reflect Generally Accepted Standards of Care,”](#)

with references listed for each principle

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