Filing An Appeal Based On a Parity Violation

KENNEDY FORUM ISSUE BRIEF (JUNE 2017)

THE KENNEDY FORUM

Contents

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Introduction

The United States is respected around the world as a leader in the development of medical breakthroughs in life-saving drugs and vaccines, surgical procedures such as transplants, cutting-edge medical equipment, diagnostics and molecular medicine. These advancements, among others, have transformed the global health care system. However, the U.S. does not garner the same respect for its health insurance system. Despite this, some elements of how the U.S. offers insurance coverage, including wellness and population health techniques, are studied internationally. Many U.S. developed interventions and innovations have optimized clinical outcomes where the health care dollar is often limited.

Despite medical advances, a primary area of frustration for many Americans enrolled in private or public sponsored health insurance arrangements is how insurers make coverage determinations for medical and pharmaceutical care. Often, coverage is denied using esoteric terms such as the care is not "medically necessary" or the care is considered "experimental" or "investigational." What makes the situation even worse is the complex and fragmented appeals system that Americans and their attending providers must use when asking an insurer, payer, or other entity, to reconsider the denial or adverse determination. Patients, their families and caregivers are often not aware of their appeal rights or knowledgeable about other due process protections afforded them by law.

Individuals with behavioral health conditions are often some of the most vulnerable and, their health is closely dependent upon how and when health plans decide to cover their care. Historically, mental health and substance use disorder treatments were subject to more restrictive limits than medical and surgical services, resulting in frequent care denials and other adverse determinations. Prior to 2008, these unequal medical management practices were legal in many states. Thus, individuals typically could not use the appeals process to question unfair and harmful decisions based on inequities between how an insurer was covering medical/surgical care versus behavioral health care. However, under the Federal Parity Law, health insurers must treat behavioral health benefits the same as physical health benefits, giving new and increased protections to consumers accessing care.

> It is time to rethink and improve on the existing health insurance appeal system with an eye towards making the appeals process more efficient, transparent and meaningful.

This issue brief describes different types of potential parity violations to illustrate one's right to file an appeal based on how health plans treat physical health services differently than mental health and substance use disorder (behavioral health) treatments. The analysis focuses on how protections founded within the Federal Parity Law can be used as a vehicle to increase access to the appeals process.

In addition, this policy paper provides a concise overview of how the appeal system works (or does not work) for individuals with behavioral health conditions. The appeals process, especially for parity violations, remains a complex and confusing system for stakeholders.

It is time to rethink and improve on the existing health insurance appeal system with an eye towards making the appeals process more efficient, transparent and meaningful. A robust appeal system also will create a deterrent effect if those who inappropriately deny care are held accountable. The Kennedy Forum recommends 10 action steps to help improve the health insurance appeal system:

1. Increase awareness of the appeal process
2. Promote more due process and transparency
3. Allow attending providers and other advocates to file appeals
4. Simplify the appeals process
5. Standardize the appeal system across market segments and state lines
6. Upgrade the external review process
7. File more appeals
8. Leverage technology to improve efficiency
9. Update oversight regulations
10. Promote advocacy and education programs.

While this report focuses on behavioral health disorders, these recommendations apply to all types of health insurance appeals, and would benefit everyone who is seeking a reconsideration for care that has been denied by a health plan.

A Family Health Crisis

On her 18th birthday, a young woman attempted suicide after struggling with depression, anxiety, and several substance use disorders. Thankfully, her attempt was unsuccessful and her family found appropriate care at two residential treatment facilities. Over the course of a year, she addressed the underlying issues associated with both her mental health issues and history of addiction. Her treatment, which cost the family over $75,000, was not covered by the family's health insurance coverage. Today, she is a successful young professional who continues to use the coping mechanisms learned in treatment.

The young woman's parents were so overwhelmed with their daughter's situation and the complicated appeal system that they never sought reimbursement by filing an appeal. All too often, in the throes of serious illness, families and friends must scramble to find care for a loved one in crisis. To add insult to injury, this care may be unlawfully denied, leaving many patients grappling with astronomical health care bills that may affect the entire family for years to come.

If this family had not underwritten the cost of treatment, the outcome would likely be much different; they took out loans and a second mortgage to cover life-saving care for their daughter. Many Americans do not have such options.

Promoting Mental Health Parity

To level the playing field and achieve equity for individuals suffering from addiction or mental health issues, a coalition of stakeholders worked together to pass the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (The Federal Parity Law). The law and subsequent regulations are focused on ending discriminatory health insurance practices against those with behavioral health conditions.

As medical expenses continue to rise, both private and public payers such as commercial insurers, employer self-funded plans, Medicaid, and state and local governmental health plans, often rely on medical management practices as a cost containment strategy. This includes utilization management (UM) programs that review and approve care prior to treatment (i.e. pre-authorization or prospective UM), ongoing treatment and services (i.e. concurrent UM), and reimbursement of medical claims (i.e. retrospective UM). While both physical and behavioral health benefits are subject to these practices, many payers continue to apply treatment limitations to behavioral health services that are more rigorous than those applied to physical health benefits, often to save money.

These restrictions on coverage can take many forms but largely fall within three categories: financial requirements, quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs):

- Financial requirements include premiums, deductibles, co-payments, and other forms of cost-sharing.
- Quantitative treatment limitations include visit and day limits, also known as length of stay limitations.
- Non-quantitative treatment limitations include utilization management strategies that restrict or deny access to care, such as prior authorization requirements (which involve "medical necessity" reviews), step therapy or fail-first protocols, and geographic restrictions.

The unequal application of these practices to behavioral health can constitute a violation of federal and state parity laws. The Federal Parity Law prevents health plans from applying financial requirements or treatment limitations (both quantitative and non-quantitative) to behavioral health benefits that are more restrictive than those applied to physical health benefits. Further, plans cannot apply separate treatment limitations only to behavioral health benefits. Through these requirements, the law aims to end the discriminatory application of inequitable medical management practices.[1]

The Federal Parity Law prevents health plans from applying financial requirements or treatment limitations (both quantitative and non-quantitative) to behavioral health benefits that are more restrictive than those applied to physical health benefits.

Appeals Overview

If a patient or their attending provider believes that a health plan has wrongfully issued a coverage denial, or has not covered behavioral health services in the same manner as services offered on the physical health side, they can usually file an internal appeal with the health plan. Under many circumstances, they may also follow with an external appeal. Health plan appeals are subject to federal and state rules establishing minimum standards for notice, qualifications of reviewers, timeframes for decisions, and other aspects of the process.

Although the Federal Parity Law and the rules governing health plan appeals do not establish a distinct category of parity appeals, potential parity violations may be raised in both internal and external appeals. (For simplicity's sake, such appeals will be referred to below as "parity appeals"). If the patient or their designee is still dissatisfied with the outcome of the internal appeal, in many cases the patient may then request an external review—by either a state agency or an independent review organization (IRO). The patient may or may not have access to an external appeal depending on several factors, including the nature of the denial or adverse benefit determination (where a plan denies or limits coverage or payment for the requested behavioral or medical treatment or services), type of insurance, and where the patient lives.

Often, when a denial of care is issued by a health plan, the patient is unaware of their right to appeal that decision. Even though up to 24 percent of all health care claims are denied, many Americans do not know where to file an appeal.[2] In fact, a 2015 Consumers Union study found:

- Two-thirds of privately insured Americans are uncertain about which state entity is responsible for resolving issues with health insurance billing;
- Most (87 percent) do not know the state agency/department tasked with handling health insurance complaints; and
- Many (72 percent) are unsure if they have the right to appeal to the state/an independent medical expert if their health plan refuses coverage for medical services they think they need.[3]

Although the Federal Parity Law and the rules governing health plan appeals do not establish a distinct category of parity appeals, potential parity violations may be raised in both internal and external appeals.

The first step in appealing a denial of care, or another adverse determination related to health insurance coverage, is to file an internal appeal with the health plan. In many cases, the internal appeals process must be exhausted before the person filing the appeal is "eligible" to move to an external review. Typically, two entry points are available to initiate an appeal:

- **Medical Necessity or Clinical Appeal:** The first entry point is to file a clinical or medical necessity appeal. An insured individual, family member or attending or designated provider will file this type of appeal when the health plan has denied or reduced the level of care based on what the plan deems is "medically necessary." This decision is based upon evidence-based medical necessity criteria or guidelines that must be fully accessible to the interested parties. Under federal and state law, health plans are required to provide a written explanation for medical necessity denials. Such denial letters should include a detailed explanation of why the patient does not meet the plan's clinical criteria and a description of the evidence reviewed by the plan, and should address evidence submitted by the patient or their provider. Without such information, it can be very difficult to lodge a meaningful appeal.
- **Administrative Appeal:** The second entry point is to file an administrative or grievance procedure appeal. This type of appeal typically addresses a non-clinical issue and is filed when there is a dispute about the level of benefits covered by the specific health plan, such as a non-covered benefit or exclusion. Some types of denial based on exclusions, such as "experimental treatment" denials, may be appealed via the medical necessity pathway.

Both entry points can be used to lodge a complaint involving a potential parity violation, depending on the specifics.

Unfortunately, the appeals process is complicated and varies depending on the type of insurance you have. The initial appeal with the health plan, also referred to as the internal appeal, may have one to three levels of review depending on the patient's insurance coverage. In addition, different timeframes and process requirements exist depending on whether the appeal is based upon a pre-authorization or prospective review (before the care is rendered), concurrent review (while the patient is receiving initial care), or retrospective review (after the care has been rendered and reimbursement is being sought). The urgency of the requested medical care, as determined by the attending provider, will also have an impact (i.e. standard care versus urgent care). An appeal can usually be lodged over the phone, but it is advisable to keep notes about all conversations with health plans (including date, time, name of health plan representative, and information discussed), and to follow up in writing to create a record of the appeal.

To optimize the chance of an appeal being successful (i.e. overturning the original decision to deny care), the patient or their attending provider must carefully identify and document the reasons why the insurer should cover the requested procedure or service. The medical necessity "review criteria" used by health plans may have built into their standards some flexibility to accommodate patients who could benefit from the additional procedures or services. Clarity, documentation and persistence is key. In addition, designated timeframes are required to be followed during the appeals process. The health plan is responsible for providing information on any such appeal requirements to the patient at the time of initial enrollment, when a service is denied and during the appeals process.

To optimize the chance of an appeal being successful (i.e. overturning the original decision to deny care), the patient or their attending provider must carefully identify and document the reasons why the insurer should cover the requested procedure or service.

If possible, the attending provider should draft a letter of medical necessity that explains why the patient satisfies each element of the health plan's medical necessity criteria, and noting why the plan's reasons for issuing the denial are flawed. The attending provider should also include with the letter any important clinical information (including medical records) that may not previously have been supplied to the health plan. For example, if a patient with a mental health diagnosis such as major depressive disorder is also suffering from an opioid use disorder, the health plan should be made aware of both diagnoses, as the patient may require more intensive treatment.

After the internal appeal process has been exhausted, the insured individual, family member, attending provider or advocate may be able to file an external appeal. An independent review organization (IRO) is typically responsible for reviewing the appeal at this juncture. Again, timeframes and process requirements will vary depending on the type of insurance coverage.

Throughout the appeals process, the patient or advocate should also consider filing an appeal or complaint with the following entities, particularly if they feel that they are getting stonewalled or otherwise being short-changed regarding their rights:

- A state or federal government agency which oversees the patient's health plan
- An accreditation agency which has accredited the patient's health plan
- An arbitration claim or court action.

Parity Violation Explained

When an adverse benefit determination involves a claim or treatment for behavioral health services, some additional due process protections can come into play. In fact, the Federal Parity Law and related state laws impose requirements that can provide additional grounds for patients and their attending providers to appeal health plan denials.

While the Federal Parity Law does not require a health insurance plan to offer behavioral health services, plans that choose to offer such benefits must provide them in a manner that is equitable to medical/surgical benefits. For example, if a plan covered as many appointments as needed with an immunologist, but only covers five appointments with a psychiatrist, this limitation would likely violate the Federal Parity Law.

The Affordable Care Act (ACA) expanded the protections provided by the Federal Parity Law. Prior to the ACA, the Federal Parity Law only applied to large group employers, Medicaid managed care, and Children's Health Insurance Program (CHIP) plans. Following the ACA, qualified health plans (individual and fully-insured small group health plans offered in and outside the health insurance exchanges) must include behavioral health benefits at parity as an essential health benefit offered to members. Additionally, the benefits offered to the Medicaid expansion population must include behavioral health benefits, and some states require that fully insured plans provide such benefits.

A parity law violation can take many forms. Some policies and practices covered under the parity law are easily measured by a dollar amount or a number. This includes, for example, financial requirements such as co-payments or deductibles, and quantitative treatment limits (QTLs) such as day and visit limits. Under the Federal Parity Law, financial requirements and QTLs cannot be more restrictive for behavioral health services than for medical services in the same class of benefits.

Other health plan practices or policies that limit benefits are called non-quantitative treatment limitations (NQTLs) because these limitations cannot be measured by a dollar amount or number. The basic rule is that a health plan cannot impose an NQTL that is not comparable, or that is applied more stringently, to behavioral health benefits than to physical health benefits. Examples of NQTLs include, but are not limited to:

- **Limits on the quantity or frequency of treatment:** If a health plan requires an automatic review after an arbitrary day or visit limit has been reached for mental health or substance use disorder treatment, but does not require such a review for medical or surgical benefits, the health plan may be in violation of the Federal Parity Law.

- **More restrictive prior authorization policies for behavioral health:** Many health plans require prior authorization for non-emergency inpatient facility or hospital services, both for medical surgical and behavioral health care. However, if a health plan's prior authorization procedure routinely approves up to seven inpatient days for medical services but just three inpatient days for behavioral health inpatient services, the plan is likely in violation of the Federal Parity Law. The parity violation is the result of the health plan applying the prior authorization process more stringently to behavioral health services.

- **Excessive concurrent review policies:** When a patient is admitted to an inpatient or residential treatment facility or day treatment, or needs long-term outpatient counseling, health plans may periodically review the medical necessity of the treatment by a process known as concurrent review. If health plans require concurrent review too frequently or impose overly burdensome requests on behavioral health care providers as compared with medical care providers to justify continued treatment, the plan may be in violation of the Federal Parity Law.

- **Step therapy or fail-first protocols:** Sometimes health plans require patients to try and fail at a lower level of care before they will approve a greater benefit. For example, a plan may require patients to try intensive outpatient services or partial hospitalization for behavioral health treatment before they will approve inpatient treatment. The plan is in violation of the Federal Parity Law if it does not have a fail-first requirement in place for obtaining inpatient medical treatment.

Some of these parity issues, such as imposition of fail-first protocols, may be relatively easy to spot in a coverage denial. However, other issues, such as excessive concurrent review policies, are harder to identify. In both cases, additional information is needed about the plan's policies and procedures to determine whether behavioral health benefits are being administered more stringently than physical health benefits.

The Federal Parity Law reinforces and augments health plans' obligations regarding transparency and disclosure of information used in making an adverse benefit determination. Specifically, plans are required to provide to consumers, free of charge:

The Federal Parity Law reinforces and augments health plans' obligations regarding transparency and disclosure of information used in making an adverse benefit determination.

- The specific reason for the denial of the requested service or claim
- A copy of the plans' medical necessity or benefit criteria for behavioral health (plans must provide this on request to any person)
- The plan's medical necessity criteria for medical/surgical benefits
- A description of the plan's processes, strategies, evidentiary standards and other factors used to apply nonquantitative treatment limitations (e.g., prior authorization policies, step therapy protocols, geographic restrictions) for both physical and behavioral health benefits.

In sum, upon request, plans must supply details regarding their parity compliance review and testing process, including any medical management procedures used in making medical necessity determinations. Such information must be specific. For example, general statements that a health plan complies with parity, or that the plan applies the same set of factors to determine utilization management procedures for physical and behavioral health benefits, are insufficient.

Because the Federal Parity Law requires comparable application of utilization management practices, the disclosure of detailed information for both the behavioral health treatment at issue and a comparable physical service is necessary to determine if a parity violation took place. Ideally, the consumer will have this information in hand before submitting an appeal, but in many situations (especially if the denied treatment is urgently needed), an appeal will need to be lodged in conjunction with a request for parity compliance information.

To learn more about parity appeals, check out the *Parity Resource Guide* at ***www.thekennedyforum.org***.

Filing a Parity Appeal

If this information appears complicated, you are not alone. In fact, the appeals process is so daunting that fewer than one out of 10,000 eligible individuals request an external review of a denied health care claim.[4] However, the good news is that persistence can pay off. Data collected by the U.S. Government Accountability Office (GAO) found that 39 to 59 percent of internal appeals were reversed in favor of the consumer.[5] This trend also continued for external review of denied claims—a study conducted by America's Health Insurance Plans (AHIP) found that 40 percent of external appeals were reversed in favor of the claimant in 2003 and 2004.[6]

If a patient, patient's family or provider believes care has been unlawfully denied, a good first step is to file an appeal with the health plan's clinical or administrative appeals system. Adding a parity law compliance challenge to the appeal will require a health plan to provide additional disclosure of information, documents, and the plan's parity compliance review and testing process. The patient or their advocate should review the plan's appeals process and timeframe requirements and be prepared to jump through some of the bureaucratic hoops associated with most appeals.

Additionally, patients, providers, friends and family members should consider registering a complaint with the Kennedy Forum's Parity Complaint Registry and Appeal Resource. This online tool was created to provide valuable information and resources for those preparing to register a complaint or an appeal with a health plan or regulatory agency.

By registering a complaint with ***www.parityregistry.org***, patients can help the Kennedy Forum identify, collect and document important information to use with regulators and health plans to correct problems and develop solutions. The data will also help us to study regional and national trends on the types of parity violation complaints that are being filed. This will help with making a data-driven case to policymakers to improve behavioral health coverage.

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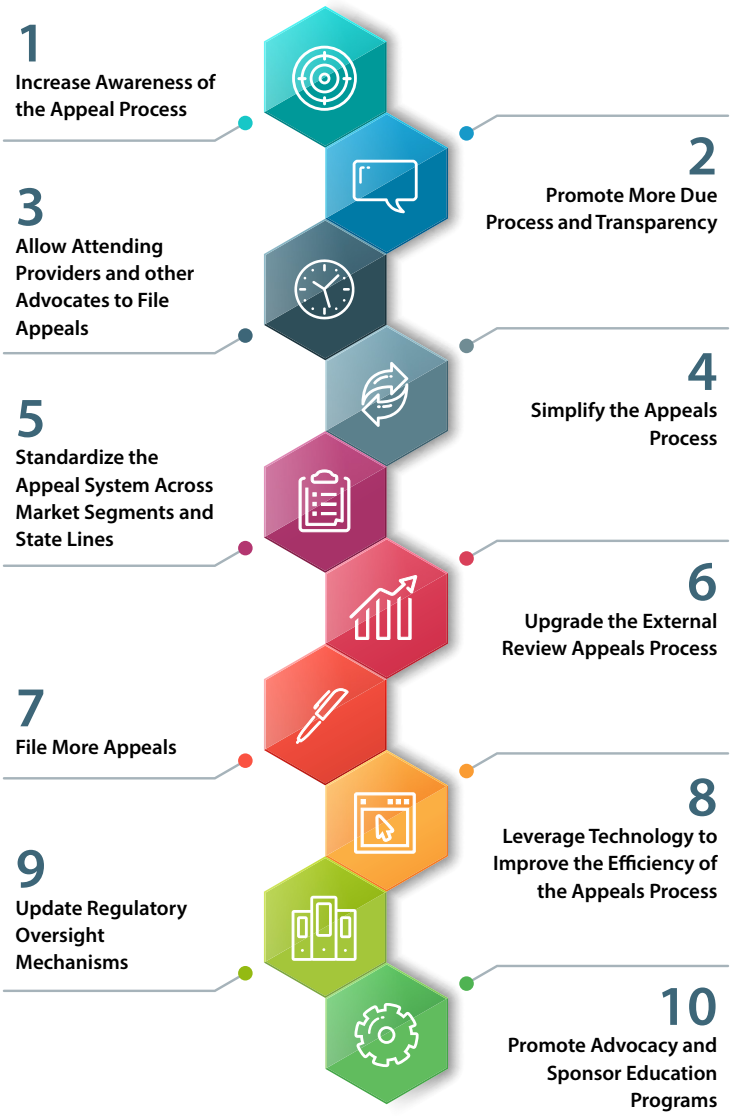
Call to Action: Ten Steps

Although many success stories exist where a patient or ordering provider's appeal was handled in a timely and efficient manner by a health plan, those cases are the exception and not the norm. The good news is that the building blocks to achieve true parity implementation are now in place, but more remains to be done. The following ten steps will advance mental health parity by improving the appeals process for all:



1. **Increase Awareness of the Appeal Process.** The appeals process is enormously complex. Many individuals do not know they have the right to file an appeal upon receiving an adverse benefit determination. Health plans and regulators should work together to ensure that all enrollees are aware of their rights through targeted public education campaigns. Regulators should also reinforce health plans' parity disclosure requirements and make clear that in both internal and external appeals, a parity violation is grounds for reversal of a coverage denial.

2. **Promote More Due Process and Transparency.** When an adverse benefit determination or denial takes place, more transparency must be provided surrounding how the decision was made and documented. At a minimum, health plans must disclose the clinical and/or coverage criteria used in the decision and clearly explain the specific steps required to file an appeal. Regulators should also enforce requirements that denial letters include a detailed explanation of why the patient does not meet the plan's clinical criteria, a description of the evidence reviewed by the plan, and address evidence submitted by the patient or their provider. Otherwise, consumers cannot avail themselves of their appeal rights.

3. **Allow Attending Providers and other Advocates to File Appeals.** In some instances, ordering or attending providers are not allowed to file an appeal on behalf of their patients. This is counterintuitive and inefficient as the provider is often in the best position to understand the denial decision and then explain why the service or treatment is still recommended or why the care was already delivered. Providers also have a "leg-up" as they are familiar with the medical jargon used in the denial letter or throughout the appeals process.

4. **Simplify the Appeals Process.** Many patients and ordering providers complain that too many bureaucratic hurdles and inconsistent requirements exist within the appeals process. These obstacles have a chilling effect that discourages patients or their representatives from filing an appeal. Originally, the appeals process made clear that utilization management (UM) appeals handled medical necessity or clinical denials, and grievance procedure appeals handled administrative denials. Today, model laws from the National Association of Insurance Commissions (NAIC) and many jurisdictions have issued regulations that have eroded this formerly clear bifurcation. We recommend that one integrated and streamlined appeals process apply no matter the basis of the initial denial.

5. **Standardize the Appeal System Across Market Segments and State Lines.** A national and consistent standard must be implemented to make the appeals process effective. At present, many different appeal pathways exist. These pathways vary based on how the health plan is regulated, the type of coverage provided, the type of plan sponsor, the jurisdiction, the type of denial (e.g., based upon a medical necessity or benefit determination), the timing of the denial (e.g., prospective, concurrent and retrospective), the urgency of the care being requested (i.e. standard care versus urgent care), and where the patient is in the appeals process. Our goal should be to establish one national appeals standard that promotes transparency, fairness and due process to all parties involved. We can accomplish this unified system through new model legislation, accreditation standards and Requests for Proposal (RFP) requirements.

6. **Upgrade the External Review Appeals Process.** Currently, the patient or their authorized representative must specifically request an external review of their claim. In most cases, the external review appeal only can be pursued after a patient first successfully completes an appeal through the health plan. In some instances, the aggrieved party may not even know they have the right to appeal to an external party. One simple way to address this confusion is to automatically refer the appeal to an independent review organization after the internal appeal is completed. For example, Medicare beneficiary appeals are automatically referred to the external review level, resulting in more due process.

In addition, the external review process as currently regulated should be re-examined and potentially upgraded to better protect consumers. Ideas include:

- **Reviewer Identification.** In many cases, the patient does not know who made the final ruling during the external review. Should the identity of the external reviewer be revealed or remain anonymous? Does due process require the person making the judgment to be disclosed like a judge in court? The Kennedy Forum recommends that the identity of the reviewer be routinely disclosed.

- **Public Disclosure of Decisions.** In some states, regulators post de-identified external appeal decisions on their websites, a practice that allows consumers and providers to understand the types of issues being sent to external appeals, how external decisions are made, and to identify trends (such as frequent overturns of denials of coverage for specific treatments). Greater disclosure of external appeal decisions would benefit individual consumers and help frame dialogue with health plans regarding practices that should be reformed.

- **Payment.** In most cases, health plans contract with two or more external review organizations to handle the external reviews of their insured population. Does the external review organization have an incentive to rule in favor of the health plan if the health plan also is paying for the cost of the external review? Should the patient's health plan pay for the external review? Or should it be funded by a government agency or through some sort of fund supported by all health plans in a particular jurisdiction? The Kennedy Forum recommends that some sort of payment system be set up through the local jurisdiction rather than through the health plan to avoid any perceived or real conflicts of interest that might bias the external review decision in favor of the health plan.

- **Exhausting Internal Review.** Should the patient or their advocate always have to exhaust the health plan internal appeals process before filing an external appeal? Should the patient have the right to skip right to external review? The Kennedy Forum recommends that the patient be permitted to skip the internal UM appeals process and go right to external review if that is their decision. However, once this decision is made, the patient or their advocate loses the right to use the health plan's internal appeal system for that particular issue under dispute.

7. **File More Appeals.** While working to lower the number of denials issued on claims, stakeholders should simultaneously work to ensure that every questionable denial is subjected to the appeals process so that enrollees receive the care they are entitled to. Each stakeholder group should do the following to promote the filing of appeals:

   - **Consumer/Provider.** Every patient who has experienced a denial or care restriction of mental health or addiction services should file a complaint at ***www.parityregistry.org*** and/or with the applicable government agency. Filing a complaint will help us develop comprehensive data to better understand the different types of parity denials.

   - **Industry.** When an appeal is filed, health plan personnel must make a good faith effort to respond in a timely and meaningful manner. Health plans and medical management organizations must ensure they are complying with existing regulations and the patient's plan documents on how these appeals should be processed (e.g., timeframes, disclosure requirements).

   - **Policymakers/Regulators.** Policymakers and public officials must ensure they enforce existing state and federal regulations on how appeals should be filed and processed. In addition, the current regulatory and accreditation requirements should be updated to create a more efficient and effective appeals process for all parties.

8. **Leverage Technology to Improve the Efficiency of the Appeals Process.** Much like TurboTax has helped tax filers, it is time to leverage technology to promote a more efficient appeals process. All too often, the appeals process is still paper-based or otherwise very fragmented. While ***www.parityregistry.org*** is one step in the right direction, more can be done.

9. **Update Regulatory Oversight Mechanisms.** It is time to update regulations to capture recent trends in how best to monitor and promote the appeals process. This could include updating the model laws, regulations and accreditation standards covering utilization management, grievance procedures, external review and mental health parity compliance, both at the federal and state levels. It also could include promoting value-based and outcome measures. Regulations need to keep pace with changes in health care delivery, technology capabilities, and communication platforms.

10. **Promote Advocacy and Sponsor Education Programs.** States should sponsor and subsidize experts who can help patients understand, file, and process appeals by creating consumer advocate offices, like the Office of the Health Care Advocate in Connecticut or Health Law Advocates in Massachusetts. Regulators and health insurers can support this effort through customer service lines, supplemental educational programs, broker materials and other resources that are specific to their agency or plan. These agencies should also actively connect consumers interested in filing an appeal with non-profits capable of supporting individuals throughout the process.

Final Thoughts

The appeals process, especially for parity violations, remains a complex and confusing system for most stakeholders. It is time to rethink and improve on existing appeal systems with an eye towards making the appeals process more efficient, transparent and meaningful. The impact of doing so will be meaningful for individuals—and their families—who need and deserve care and are entitled to services.

For more information on this topic, contact Garry Carneal, JD, Senior Policy Advisor, The Kennedy Forum, at ***info@thekennedyforum.org***. See also ***www.thekennedyforum.org***.

About The Kennedy Forum

A Message from Patrick J. Kennedy

I founded The Kennedy Forum in 2013 as a way to convene cutting-edge thinkers who are united by the potential for reform in behavioral health service delivery made possible by new laws, revolutionary technologies and an enhanced understanding of effective services and treatments. Our inaugural event in October of that year called for The Forum to develop a platform to advance thinking across a host of issues in our field. To meet this demand, The Kennedy Forum is organized as a think tank poised to drive real, lasting and meaningful policy change to bring the nation closer to fulfilling President Kennedy's vision as outlined in the 1963 Community Mental Health Act.

Today, The Kennedy Forum's work is not singular in its focus. We are promoting mental health coverage through a series of initiatives, which include:

- Ensuring health plan accountability and compliance with the letter and spirit of the parity law by educating consumers, providers, and regulators, so that each group holds themselves and others accountable for proper enforcement.
- Establishing ways to promote provider accountability through evidence-based outcomes measures that are validated and quantifiable.
- Implementing proven collaborative practice models that promote the integration of mental health and substance use disorder services into mainstream health care.
- Using technology to optimize electronic/digital communications and enhance assessment/treatment tools.
- Promoting brain fitness and wellness, which includes identifying opportunities to translate neuroscience research findings into preventive and treatment interventions.

Please visit our website, ***www.thekennedyforum.org***, to track our ongoing activities in support of these five initiatives and other activities central to The Kennedy Forum's mission.

Patrick J. Kennedy
Founder

Endnotes

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