



Mental Health Parity in Private Health Plans: Overview of Requirements & the Right to Information

Abbi Coursole & Elizabeth Edwards

What Is Mental Health Parity?

Federal law requires health insurance plans that offer coverage for both behavioral and physical health benefits to provide a **similar level of benefits** (also known as parity) for mental health and substance use disorder services (behavioral health services) as for physical health services. Among other things, parity is supposed to make sure it's not harder to get behavioral health services than to get physical health services. Many states also have parity laws which either mirror the federal law or impose stricter requirements on health insurance plans.

Does My Private Health Plan Have to Comply with Parity?

Probably. Most private health plans are required to comply with parity rules. If you are enrolled in one of the following health plans, your plan must comply.

- The Federal Employees Health Benefits Program
- Health plans purchased through health insurance marketplaces (ex. Covered California)
- Most individual and group health plans purchased outside health insurance marketplaces
- Some state and local government health plans
- Group health plans for employers with 51 or more employees
- Most group health plans for employers with 50 or fewer employees

The plans above are required to comply with parity laws. If you get your mental health services from one of these plans, it must make those services available similar to other covered services.

There are a few types of private health plans that are exempt from parity requirements. This includes certain self-insured employer plans and most aspects of Medicare plans. Your state Department of Insurance should be able to provide information as to whether your plan is exempt from parity requirements.

Which Services Must Be Covered Equally Under Parity Laws?

- In-patient in-network and out-of-network services
- Out-patient in-network and out-of-network services
- Intensive out-patient services
- Residential treatment
- Emergency care
- Prescription drugs
- Co-pays, deductibles, and maximum out-of-pocket costs (these costs are generally referred to as “cost-sharing”)
- Types of facilities
- Provider reimbursement rates
- Clinical criteria used to approve or deny care (standard to determine whether treatment is “medically necessary”)

What Are Some Signs That a Private Health Plan Is Violating Parity Laws?

- Cost sharing, like co-pays, for mental health services are higher than for other services.
- The health plan requests that you call and get permission before you access mental health services but not other services
- The health plan covers residential treatment for physical care conditions but not mental health or substance abuse treatment. Or that the health plan only offers residential treatment for behavioral health treatment, but offers community-based services physical health treatment
- The health plan denies coverage for mental health services because they are not “medically necessary” but upon request does not provide you with the criteria it used to determine medical necessity. Read more about what health plans must tell you in the section below

How Can I Find Out If My Private Health Plan Is Meeting Parity Requirements?

Your private health plan must provide you with information about how it complies with parity laws if you ask. Call your plan for this information.

- If you ask for a mental health service and your plan says no, you can ask for information about how it made that decision, and how it decides requests for similar, non-mental health services. This information should include:
 - The plan language that limits the service and the services those limits apply to, including mental health and physical health services

- The factors used in the development of the limitation, which may include recent cost increases, excessive use of the service, and the safety and effectiveness of the treatment
- The sources used to evaluate the factors described above, such as processes, strategies and evidentiary standards
- The methods and analysis used to develop the limitation
- Evidence and documentation that the limitation is not used more stringently, as written and in operation, for mental health services

What if I Think My Private Health Plan is Not Meeting Parity Requirements?

A health plan may violate parity requirements in how it offers, approves, or delivers services, and it may violate parity by not providing the required parity information when requested.

Complaining about parity compliance will usually start with filing a grievance with your health plan. There should be instructions on how to do this in your member handbook or on the health plan's website. The plan is required to follow certain deadlines in response to your grievance.

The state Department of Insurance is supposed to make sure that your most private health plans meet the parity requirements. You may call your state's Department of Insurance if you think your private health plan is violating parity rules. There is usually a process for filing a parity complaint about your private health plan with your state's Department of Insurance.

Important: If you have been denied a behavioral health service, you should have received a letter or other notice that tells you why and how to appeal that decision, including important deadlines for filing the appeal. This notice should also tell you how to access your file and the reasons why the service was denied so you know what to prove in an appeal. If you want to complain about a denial of a service, follow the process outlined in the notice sent to you.