



Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services

If you are someone who is trying to figure out how to use your health coverage provided by your employer to pay for your mental health or substance use services – this sheet is for you. Your health plan or health coverage is sometimes called *health insurance*.

Parity of mental health and substance use benefits

There is now a United States law stating that certain health plans must cover mental health and substance use (MH/SU) services comparably (in a similar way) to medical and surgical care, or what most people refer to as physical health.¹ Many simply refer to the requirement of the law as parity, as we do here.

Parity: requires that certain health plans apply certain comparable (similar) rules to MH/SU benefits as they do for physical health.

In this document, we explain MH/SU parity, answer questions about the parity law, and provide ways to learn more. We hope you use this information to get the mental health and substance use services you and your family need paid for (either fully or partially) by your health plan. You may want to talk about this information with your doctor, therapist, your family members, or others who help you with your MH/SU care.

Here you will learn about:

- Laws about parity of MH/SU benefits with other physical health benefits
- Reasons why some MH/SU benefit claims are denied
- How to file an internal or external appeal if your claim is denied
- Ways to learn more about parity, your MH/SU benefits, and appeals of denied claims.

¹ Specifically, the law (the Mental Health Parity and Addiction Equity Act or MHPAEA) requires that plans and issuers that provide mental health or substance use benefits do not impose financial requirements or treatment limitations that are more restrictive than those that apply to medical or surgical benefits. See the Mental Health Parity home page on the [U.S. Department of Labor website](http://www.dhs.gov).



Does my health plan offer parity for MH/SU benefits?

Most employer-based health plans, but not all, must offer parity for MH/SU benefits.² These are health plans that people get from where they work.

- Not all health plans are required to provide MH/SU benefits. Parity only applies to health plans that provide MH/SU benefits.
- Parity applies to private employer plans with 51 or more workers.
- Parity also applies to smaller employers that started offering benefits or made major changes to their health benefits after the Affordable Care Act came into effect in 2010. This includes most small plans.
- Parity also applies to most health insurance coverage sold to individuals. This includes coverage sold through the health insurance marketplace.³
- Health plans that are only for retirees do not need to comply with MH/SU parity.

What does parity mean in terms of MH/SU benefits?

Health Benefits: This means physical health, mental health, and substance use services paid for by health plans.

Parity means that financial requirements (such as copayments, deductibles, coinsurance or out-of-pocket maximums)⁴ and treatment limitations used by health plans must be comparable for physical and MH/SU services. There are two different sets of parity rules.

² MHPAEA applies to plans with 51 or more employees of private companies or governmental employers. MHPAEA also applies to plan of smaller groups that started offering or made major changes to their plan after March 23, 2010. (Plans that made major changes are sometimes referred to as non-grandfathered plans). For more information related to determining if the parity rules apply to a plan, see [Health Insurance Rights & Protections, Grandfathered Health Insurance Plans](#) on the HealthCare.gov website. For more information on other types of plans that do not have to follow parity, see the [Mental Health Parity and Addiction Equity Act home page](#) on the Centers for Medicare & Medicaid Services website.

³ For more information about the health insurance exchange see the [healthcare.gov website](#).

⁴ A plan's lifetime and annual dollar limits are subject to different rules under the earlier Mental Health Parity Act (MHPA) which was supplemented by MHPAEA and the Affordable Care Act (ACA). For information on MHPA, see [The Mental Health Parity Act](#). For information on the ACA's ban on lifetime and annual limits for essential health benefits, go to Affordable Care Act—About the Law on and select Benefit Limits on the [US Health and Human Services homepage](#).



The first set of rules is for financial requirements (such as rules for copayments) and for treatment limits that you can count (such as number of visits).^{5,6} The other set of rules deals with how treatment is accessed and under what conditions (such as obtaining permission from your health plan before going to MH/SU treatment).⁷

Here are some ways in which MH/SU and physical health benefits must be comparable:

- **Co-payment** (or simply co-pay). A co-pay is a fixed amount you pay for each covered service such as an outpatient doctor's visit. For example, generally if your co-pay for all outpatient physical health benefits is \$20, then your co-pay for outpatient mental health or substance use benefits must be \$20 or less.
- **Yearly visit limits.** If there are no yearly limits on all outpatient office visits to medical providers, there should generally be no yearly limit for outpatient office visits to an MH provider.
- **Prior authorization.** Prior authorization (sometimes called preauthorization, prior approval, or precertification) means that a doctor from your plan must confirm that you need a service before it begins. Generally speaking, if your health plan does not require prior authorization for any medical/surgical visits, a plan will not be able to require it for MH/SU related visits. Once your treatment begins, rules for continuing your care should be based on a comparable process for both mental health and physical health benefits.
- **Proof of medical necessity.** Medical necessity standards are used to determine appropriate care for different medical conditions. The standards are based on research showing that a treatment is effective. A health plan must use a similar process to create medical necessity standards for MH/SU services, compared to the process used for physical health services.

⁵ These usually are called *quantitative treatment limitations* or QTLs. They include the number of visits or days covered or frequency of treatment.

⁶ A plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health or substance use benefits in any classification that is more restrictive than the *predominant* financial requirement or quantitative limitation of that type applied to *substantially all* medical/surgical benefits in the same classification.

⁷ These are usually called non-quantitative treatment limitations or NQTLs. NQTLs deal with how treatment is given and under what conditions (such as medical necessity or prior authorization requirements). A plan may not impose an NQTL with respect to MH/SU benefits unless *any processes, strategies, evidentiary standards, or other factors used in applying the limitation to MH/SU benefits are comparable* to and applied no more stringently than those used in applying the limitation with respect to medical/surgical benefits.



To learn more about financial requirements, treatment limits, and other MH/SU parity issues go to the [Frequently Asked Questions for Employees about the Mental Health Parity and Addiction Equity Act](#) on the U.S. Department of Labor website.

How can I find out about my health plan's MH/SU benefits?

You have the right to call your plan and request information about your benefits. Sometimes a different company manages your MH/SU benefits than the one that manages your physical health benefits. For example, this may be another insurance company. You are entitled to information about your plan regardless of who manages it. There are many ways to learn about your MH/SU benefits:

- Read your health plan's *Summary Plan Description* and/or *Summary of Benefits and Coverage*. If you do not have these documents, you may request them from your health plan or employer. These documents should include information about your MH/SU benefits. However, they may not contain all of the information you need about how to access these benefits. You may also request rules for accessing your MH/SU benefits in writing from your plan. These documents also should have facts about your rights under the Employee Retirement Income Security Act (ERISA, a law that protects your health benefits and gives your certain rights).⁸
- Ask your health plan about its requirements for prior authorization or medical necessity for MH/SU benefits. The law requires that health plans make their medical necessity criteria available to you for MH/SU and physical health services for comparison. This includes telling you how those criteria were developed. Speak up if you question whether these requirements for MH/SU services are determined in a comparable manner to those for physical health services.
- You may request copies from your health plan of all information it uses to decide about co-payments, yearly limits, lifetime limits, medical necessity and prior authorization.⁹ ERISA states that your health plan must give you copies of all these materials within 30 days of your request.

⁸ For more information about ERISA, see the [Health Plans and Benefits ERISA home page](#) on the U.S. Department of Labor website.

⁹ You also can request other medical management criteria such as how a plan determines what prescriptions are covered, how a plan decides who is in its network of providers, the plan exclusions based on requirements that individuals do certain things (like complete a specific treatment) before a benefit will be covered, and limits related to where (what geographic area) a benefit will be covered.



For more information about your benefits, call your health plan directly at their customer service phone number.

- The customer service number usually is listed on the back of your health plan's card.
- Have your health plan card nearby when you call so you can quickly find your plan number, group number, and name of your employer.
- Locate your health plan's website in advance. Additional information about your plan usually can be found online by going to the websites listed in the *Summary of Benefits and Coverage*.

Why some MH/SU benefit claims are denied

Claim: This term refers to a request for payment for MH/SU services from your health plan.

Deny a claim, or a denied claim: This means that your health plan refuses to pay for some or all of the MH/SU services you received as stated in the claim.

Sometimes health plans deny claims for certain services. If they deny your claim for MH/SU services, ERISA and other laws require them to send you a letter explaining the reason they denied the claim. The letter also will have information about your right to file an appeal, with details about how and when to do so. The denial letter should be specifically about the reason why your claim for services is being denied.

Sometimes claims are denied because a health plan is not complying with the law. However, there are many reasons that health plans deny a claim that may not violate parity:

- Your health plan does not offer this service as part of your benefits.
- MH/SU services were not considered medically necessary, and the medical necessity criteria used for physical health services are comparable.
- MH/SU services are no longer appropriate in a specific health care setting or level of care. For example, you were receiving residential treatment, but based on your current symptoms residential treatment will no longer be medically necessary. So now, your health plan will only pay for outpatient visits unless your symptoms change. Physical health services are being treated in a comparable way.
- The MH/SU service was considered experimental or investigational. This means the plan thinks the service is too new and has not yet been studied enough to show that it is effective. The process for determining that a service is experimental or investigational must be applied similarly for MH/SU and physical health services.



What can I do if my health plan denies my MH/SU claim, and I suspect it is because the plan is not complying with the parity law?

Begin by calling your health plan to get more information. You can find this number on the back of your health plan's card. Have the following information when you call:

- Your bill for the MH/SU services that were not paid by your health plan.
- The Explanation of Benefits (EOB). This is a summary of which services were paid by your health plan and which services were not paid. Your health plan should send this to you. It should include a denial code and a statement that explains why a service was denied or not covered.
- Your health plan's *Summary Plan Description* or *Summary of Benefits and Coverage*. It helps to mark the pages that refer to MH/SU benefits before calling your health plan.

You have the right to request information about the treatment limitations the plan used to deny your claim. You can also request the treatment limitations for your physical health benefits to check if comparable treatment limitations apply to your MH/SU benefits. You also have the right to request information about how treatment is accessed under your plan, although it can be harder to identify when plans break rules related to how treatment is accessed.¹⁰ To find this out, you can ask how your plan developed the rules for any treatment limitations. You can also ask your MH/SU provider to request information about these rules on your behalf.

Appeal: This means that you ask your health insurer or plan to review its decision. You try to get your health plan to reverse their decision.

How to file an internal or external appeal if your claim is denied

How can I appeal if I think my health plan should not have denied this claim?

You have the right to appeal a denied claim. You will need to file an *internal appeal* with your health plan. Start by calling your health plan and asking them what to include in your internal appeal request. You should include all information related to your claim in your appeal. This includes any additional information or evidence, that you want the plan to consider. Your EOB should have information about how to file this request. The request must be submitted in writing.

¹⁰ This means that it is usually easier to identify when plans break rules related to treatment limitations that you can count (QTLs) than treatment limitations that are related to processes under which treatment is accessed (NQLTs). See the section of this document titled: *What does parity mean in terms of MH/SU benefits?*



Conducting an internal appeal means that people who work at your health plan carefully review your denied claim. There may be two or more levels of internal appeals. Many appealed claims are reversed, or changed in the patient's favor. You must get a response from your health plan within 60 days of filing an internal appeal.

You can get help with an appeal:

- Your doctor or therapist, a family member, or someone you have chosen to represent you can help you. They can find out about your claim and your appeal. They can write a letter to support payment of your claim. You may need to sign a form giving them permission to help.
- In some states, a consumer assistance program may be able to help you file an appeal. You can find information for your state through the [Consumer Assistance Program home page](#) on the Centers for Medicare & Medicaid Services website.

If your health plan still denies the claim after all levels of internal appeal, you may have a right to request an *external review*. This means that an organization outside the health plan will review your case and give an unbiased opinion. This review may be conducted by an independent review organization (IRO), through the federal Office of Personnel Management's external review process, or through your state's external review process.¹¹ Your final internal appeal determination should have information on how to request an external review, if one is available to you.

You must request an external review no later than four months after getting the final denial from your health plan. Here are some reasons to request an external review:

- Your health plan says this treatment was not medically necessary. You disagree, and suspect the plan used medical necessity criteria that were not developed in a comparable way to what they used for physical health.
- Your health plan said that it cancelled your coverage retroactively, to before you received the MH/SU services. You want to challenge this decision.

The external review either will **overturn** the denial (say that the health plan needs to pay your claim) or **agree** with the health plan's denial. This decision must be made within 45 days. It is your right to take your health plan to court.

You can learn more about how to file a claim or request an external review by going to the U.S. Department of Labor web page titled [Filing a Claim for Your Health or Disability Benefits](#).

¹¹ The party that conducts the review will depend upon the type of coverage in which you are enrolled.



**Parity provides important protections
related to MH/SU benefits.
Make sure you receive the benefits
to which you are entitled!**

More ways to learn:

To learn more about the Mental Health Parity and Addiction Equity Act (MHPAEA) and your health plan's compliance with parity, call or go to the following:

- [U.S. Department of Labor Employee Benefits Security Administration \(EBSA\) web page](#) that has consumer information on health plans. Or contact EBSA toll-free at: 1-866-444-3272 or through their [website](#).
- U.S. Department of Health and Human Services: 1-877-267-2323 ext. 61565
- Your state's department of insurance website and contact information, which can be found on the [National Association of Insurance Commissioners website](#).
- [The Substance Abuse and Mental Health Services Administration \(SAMHSA\) Implementation of the Mental Health Parity and Addiction Equity Act \(MHPAEA\) page](#).

To learn more about benefits and the appeals process, go to:

- The National Conference of State Legislatures page titled [Mental Health Benefits: State Laws Mandating or Regulating](#).
- The HealthCare.gov [page on health insurance rights and protections](#).

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DISCLAIMER

This document is not meant to be considered legal advice and is not representative of the official position of the U.S. Departments of Labor, Health and Human Services, and the Treasury. This document is intended to give a basic understanding of certain requirements related to MHPAEA and claims and appeals under the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (the Code). The statute, recent regulations, and other guidance issued by the Departments should be consulted.

RECOMMENDED CITATION

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