WHAT IS Mental Health Parity?

Mental health parity means that insurance benefits for mental health and substance use conditions are equal to coverage for other types of health care.

So if your plan offers unlimited doctor visits for a chronic condition like diabetes, then it must also offer unlimited visits for a mental health condition such as depression or schizophrenia.

Does My Plan Have to Follow Parity?

The federal parity law establishes minimum standards across the country. If a state has a stronger parity law, health plans must follow the state law instead.

YES

Health plans that MUST follow federal parity include:

- Group health plans for employers with 51 or more employees
- Most group health plans for employers with 50 or fewer employees
- The Federal Employees Health Benefits Program
- Medicaid Managed Care (MCOs)
- State Children's Health Insurance Programs (S-CHIP)
- Some state/local government employee health plans
- Any health plans purchased through the Health Insurance Marketplaces
- Most individual and group health plans purchased outside the Health Insurance Marketplaces

NO

Health plans that DO NOT have to follow federal parity include:

- Medicare[1]
- Medicaid - Fee for Service
- Individual and group health plans created and purchased before March 23, 2010
- Employer sponsored plans that received an exemption based on increase of costs related to parity
- Some state/local government employee health plans

[1]However, Medicare's cost-sharing for outpatient mental health services do comply with parity.

If you are unsure about what type of plan you have, ask your insurance carrier or agent, your plan administrator, or your human resources department.

WHAT SHOULD BE EQUAL?

Benefits and Services that Must Be Covered Equally

- ✓ Inpatient in-network & out-of-network
- ✓ Outpatient in-network & out-of-network
- ✓ Intensive outpatient services
- ✓ Partial hospitalization
- ✓ Residential treatment
- ✓ Emergency care
- ✓ Prescription drugs
- ✓ Co-pays
- ✓ Deductibles
- ✓ Maximum out-of-pocket limits
- ✓ Geographic location
- ✓ Type of healthcare facility
- ✓ Provider reimbursement rates
- ✓ Clinical criteria used to approve or deny care

Signs Your Health Plan May Be Violating Parity Requirements

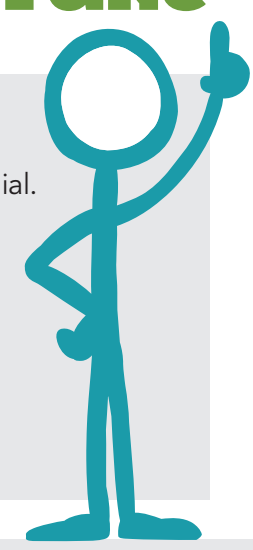
- Higher costs or fewer visits for mental health services than for other kinds of health care
- Having to call and get permission to get mental health care covered, but not for other types of health care
- Getting denied mental health services because they were not considered "medically necessary," but the plan does not answer a request for the medical necessity criteria they use
- Inability to find any in-network mental health providers taking new patients
- Lack of coverage for residential mental health or substance use treatment or intensive outpatient care but will give coverage for other health conditions

You may file a written formal appeal (ask your plan for details) or use NAMI's parity tools if your informal attempts are unsuccessful.

Steps You Can Take

for an Appeal of Denial of Services

1. Speak with your mental health professional or provider.
2. If it is an emergency have a mental health professional request an expedited appeal.
3. Confirm with your insurance company that your services will be covered during the appeal.
4. Request, or have your provider request, written notification of the reason for denial. You should receive this within 30 days.
5. Use NAMI's template letters for the appeal.
6. Meet all deadlines in the review and appeal process.



More information about appeals

View the full report on Mental Health Parity

Visit NAMI.org

Follow Us!

facebook.com/officialNAMI

twitter.com/NAMIcommunicate

NAMI
National Alliance on Mental Illness