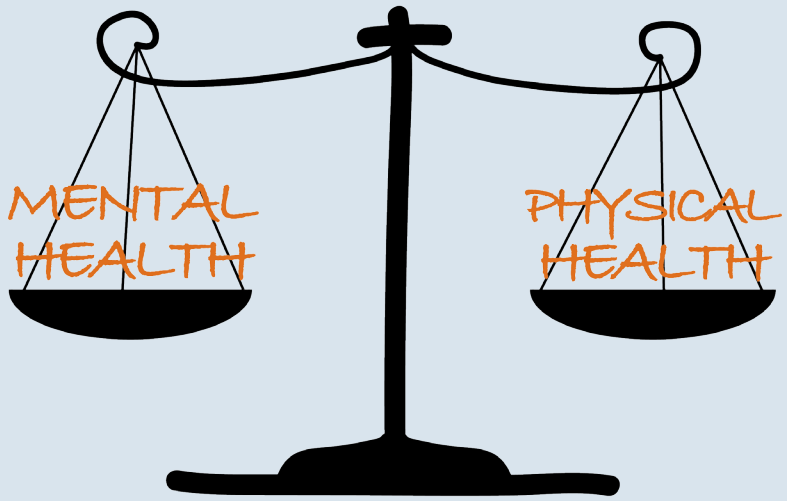
MENTAL HEALTH PARITY: KNOW YOUR RIGHTS

par-i-ty: (noun) the quality or state of being equal or equivalent



WHAT IS MENTAL HEALTH PARITY?

In 2017, the Texas legislature passed House Bill 10, a law that changed how mental health and substance use care is provided through private insurance health plans. This law strengthens existing federal protections to help ensure Texans get the mental health and substance use treatment and services they need. Federal and state parity laws require that if your health plan covers mental health or substance use services, those services must be provided at the **same level** as other medical services. Parity laws do not, however, **require** insurance companies to cover mental health or substance use services.

HISTORY

In 2008, the federal Mental Health Parity and Addiction Equity Act (MHPAEA), was signed into law requiring certain plans that offer coverage for mental health or substance use services to do so equal to coverage for physical health. While MHPAEA was a good start, there were still significant gaps to achieving true parity nationwide:

- Only large employer group plans were included in the law, leaving small employer and individual market plans out of parity protections.
- There were no definitions for types of parity violations, leaving parity compliance hard to measure and enforce.

In 2010, the Affordable Care Act (ACA) expanded parity laws to include small employer and individual market health plans. House Bill 10 strengthens federal requirements by requiring the Texas Department of Insurance (TDI) to enforce parity for all state-regulated health plans in Texas, including large and small employer plans, and those sold in the individual market. House Bill 10 also gives TDI the authority to monitor parity compliance and handle parity-related complaints for plans it oversees.

HOW TO GET HELP

There are several steps for filing an appeal after your treatment has been denied. Learn more at parityispersonal.org.

1. **Talk to your insurance company** and ask them to explain the reasons for denying the services.

2. **Obtain assistance from the Behavioral Health Access to Care Ombudsman** at the state Health and Human Services Commission (1-877-787-8999). They can help you find providers, explain insurance terms, and connect you to local resources.

3. **Find out who regulates your plan** by looking on the back of your insurance card for the letters TDI or DOL.

4. **For the letters TDI**, you have a state-regulated plan and will need to file a parity complaint with the Texas Department of Insurance (TDI). Start by contacting their Consumer Help Line at 1-800-252-3439.

5. **For the letters DOL**, you have a federally-regulated plan and will need to call the Department of Labor (DOL) Benefits Advisor for more assistance: 1-866-444-3272.

MENTAL HEALTH PARITY: KNOW YOUR RIGHTS

WHAT DOES THIS MEAN FOR YOU?

If you have an insurance plan (including most private health insurance plans, Medicaid managed care, CHIP, or Federal Employee Health Benefit Plans) that covers mental health and substance use benefits, your plan must provide those services at parity. Parity protects your right to receive mental health services and substance use services in the same way that you receive physical health services.

There are two ways to measure parity: **quantitative treatment limitations** (QTLs) and **non-quantitative treatment limitations** (NQTLs). An easy way to remember this is that QTLs are numeric and NQTLs are non-numeric. Parity laws require all private health plans in Texas to have parity for both QTLs and NQTLs.

DETERMINE IF SERVICES FULFILL PARITY RULES AND REGULATIONS

Possible Treatment Limitations	Health Plan Components	Things to Pay Attention To	What to Consider
Quantitative Treatment Limitations (QTLs)	Financial requirements	Deductibles, co-pays, and out-of-pocket limits; annual or lifetime limits on mental health care	Insurers are not allowed to require higher deductibles or charge higher co-pays for mental health services than for general medical services.
	Treatment/Service limitations	Number of visits or hospital days	The number of visits or hospital days for mental health care should be generally equivalent to those for physical health care.
	Out-of-Network benefits	Mental health providers outside of your network	If a plan offers out-of-network benefits for physical health care, then there must be out-of-network benefits for mental health care.
Non-Quantitative Treatment Limitations (NQTLs)	Prior authorization	Requirements for an insurer to review and approve mental health services to determine medical necessity	If you are not required to gain insurer approval before accessing specialty physical health care, you should not have the same requirements for mental health care.
	Medical necessity requirements	Denials for treatment based on medical necessity	Medical necessity criteria should not be any more stringent for mental health than for physical health.
	"Fail first" medication requirements	Requirements to try medications other than the preferred medication from your mental health provider	Insurers cannot treat mental health medications differently than other medications under their plans, including "fail first" requirements.
	Provider networks	Availability of providers	There should be an adequate number of mental health providers in your network.