

# Challenges with Insurance

## **What is being done about insurance companies that won't cover mental health care expenses?**

Federal laws require insurance companies to manage mental health and addiction coverages in ways that match physical health coverages. These requirements, intended to equalize access to physical and mental health services, are upheld by the [Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#), passed in 2008 and amended in 2024. States have their own laws to uphold the federal requirements and may go further in regulating insurance parity.

A [fact sheet](#) describing the 2024 amendments includes this statement: “The United States of America continues to experience a mental health and substance use disorder crisis. In the almost 16 years since the enactment of MHPAEA, disparities in coverage between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits have persisted and grown.”

At the same time, substantial cuts to the federal Medicaid program, passed by Congress in July 2025, will severely disrupt the work of mental health agencies that often rely on direct federal funding for operations in addition to what they receive in reimbursement for clients with Medicaid insurance. The Congressional Budget Office estimates that 12 million more people will be without insurance by 2034. The SMI population will be disproportionately impacted, as many people with the most severe conditions rely on state and federal benefits to cover housing and food in addition to medical care.

**To engage in advocacy related to Medicaid, reference TAC's policy statement and refer to state-by-state fact sheets developed by the National Alliance on Mental Illness (NAMI):**

- [Statement on Impact of Medicaid Cuts for those with Severe Mental Illness — TAC](#)
- [Medicaid State Fact Sheets | NAMI](#)

## What protections are supposed to be included in the federal requirements?

If mental health is included in the plan, then the insurance company is responsible to uphold federal parity law. That means deductibles, co-payments, out-of-pocket maximums, prescription benefits, etc., for physical health and mental health must match. Categorical exclusions cannot be used to limit or deny reimbursement.

The 2024 rules intend to repair some common areas of ongoing disparity, among them prior authorization, network composition, and out-of-network reimbursement rates. These topics fit within what insurers call non-quantitative treatment limitations—NQTs. The new rules affirm that insurers must evaluate data and take reasonable action if there are discrepancies in their NQTs for medical/surgical services versus mental health and substance use disorder services.

As the 2024 rules roll out, loopholes to parity remain. While the parity law requires that a private insurer cannot have more restrictive requirements for mental health than for physical health, for now it stops short of requiring all insurers to actually cover mental health services.

Even if an insurance plan includes mental health care, insurance denials are unfortunately common and the resulting burden to pay or appeal an insurance denial often falls on individuals and families with few resources. A case currently before the [Supreme Court](#) may have broad-reaching impacts into the future about whether insurance companies are held accountable to cover services that providers have said are medically necessary. Additional information about that case is included at the end of this article.

## What is important to know about the right to appeal?

The Affordable Care Act (ACA), enacted in 2010, requires insurance plans offered on the [health insurance marketplace](#) to cover mental health and addiction services. As part of the ACA, health plans must offer an internal process for consumers to file an appeal. The Centers for Medicare and Medicaid Services ([cms.gov](#)) provides information. At a minimum, insurance companies must:

- Allow consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage.
- Give consumers detailed information about the grounds for the denial of claims or coverage.
- Notify consumers about their right to appeal and instruct them on how to begin the appeals process.
- Ensure a full and fair review of the denial.
- Provide consumers with an expedited appeals process in urgent cases.

According to [CMS](#), consumers have the right to an external review if the internal review does not resolve the claim and coverage was denied on the basis of medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition, insurers are responsible to provide consumers with clear information about their right to appeal. If the consumer wins an external appeal, the health plan is expected to pay for the benefit that was previously denied.

A non-profit organization called [Cover My Mental Health](#) provides information and tools to help consumers navigate insurance denials, including sample letters for appealing a denial based on medical necessity, for example.

**Here are additional considerations:**

- If reimbursement is denied because your insurance doesn't cover mental health care, research your state's requirements related to parity. A website called [insure.com](#) provides a chart with state-specific information to help you begin.
- Find out who regulates your health insurance plan and how to file a complaint or request an investigation.
- If you are insured through a private, self-funded plan (often the case for people who work for very large corporations), then the regulator is the [U.S. Department of Labor](#) (DOL). Find the right number to call from DOL's list of [Employee Benefits Security Administration Regional Offices](#).
- If you are insured through a small or large group plan, then your state's insurance commissioner is the regulator and manages complaints. Find your state's office by typing the name of the state and insurance commissioner into your browser.
- If you have public insurance, then the regulator is the Centers for Medicare and Medicaid Services. States often have unique names for their Medicaid programs, listed in a [chart provided by the American Council on Aging](#). Contact your state's agency to ask about insurance appeal and complaint options.
- Ask for a complete written explanation for any denial from your insurance company. Read it carefully to fully understand the reasons for the denial.
- If the denial doesn't include enough information for you to understand why the claim was denied, request further explanation. For example, ask if there are treatment limits or criteria related to medical necessity. The Department of Labor provides a [form](#) to support your inquiry.
- Ask the insurance company to provide paperwork needed to appeal the denial. Request an expedited appeal for any claim related to an immediate health risk. Consider any evidence missing from the original claim that might justify the treatment as medically necessary. Include all relevant documents with your appeal and clearly describe the outcome you are seeking.

- If the denial is based on a service being out of network, collect and share evidence that there was no provider in network who could provide the medically necessary service or that there was an unreasonably long wait time.
- Ask your medical provider if you can delay payment until the appeal process is resolved. If that doesn't work, ask to set up a payment plan so a collections agency won't become involved.
- If the appeal is denied, request an external independent review. The National Association of Independent Review Organizations provides a [Patient Rights FAQ](#) with more information about this option and other topics to support consumers navigating an insurance denial.

## **Advocacy and litigation are ongoing**

A landmark case against United Behavioral Health is an example of how parity law is still being interpreted by the courts. In August 2023, the Ninth Circuit Court of Appeals [reconsidered](#) portions of the District Court findings in *Wit v. United Behavioral Health*. The case, which made its way to the [Supreme Court](#), has captured the attention of advocates nationwide who are shining light on a general failure to uphold parity laws that were intended to shore up at least part of the fractured treatment system. The [Kennedy Forum](#) is engaged in this advocacy work and tracking government response to the issues.