



What can I do when insurance 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 of 2008](#). States have their own laws to uphold the federal requirements and sometimes go further in regulating insurance parity.

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. must match between physical health and mental health. Categorical exclusions cannot be used to limit or deny reimbursement for services.

However, too few resources are committed to ensuring that parity laws are upheld — and there are loopholes. While the parity law requires that a private insurer cannot have more restrictive requirements for mental health than for physical health, 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 [2023 Mental Health America report](#) includes data about the high cost of care and barriers to treatment that are related to insurance. The report includes information about the Affordable Care Act (ACA), enacted in 2010, which requires insurance plans offered on the [health insurance marketplace](#) to cover mental health and addiction services.

As part of the ACA, new health plans begun on or before Sept. 23, 2010, also are required to offer an internal process for consumers to file an appeal. The Centers for Medicare and Medicaid Services ([cms.gov](https://www.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](https://www.cms.gov), 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.

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](https://www.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](https://www.dol.gov) (DOL). Find the right number to call from DOL's list of [Employee Benefits Security Administration Regional Offices](https://www.dol.gov/ebsa/region).
 - 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. Contact your state agency responsible for Medicare and Medicaid 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 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 the case, as well as providing a [complaint portal](#) that consumers can use to report denials of coverage for mental health or addiction services.