TENNESSEE PARITY PROJECT

INSURANCE FAIRNESS:

MENTAL HEALTH AND SUBSTANCE USE INSURANCE COVERAGE

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WHAT IS **“INSURANCE FAIRNESS” ?**

Insurance fairness is the basic idea that mental health and substance use disorder treatment and services are covered at the same level or on “par” as care for other health conditions. This is commonly called insurance “parity.” State and federal laws have attempted to address discriminatory practices in health insurance by creating requirements around parity.

WHY IS **INSURANCE FAIRNESS OR “PARITY” IMPORTANT?**

Health insurance should help millions of Americans get the behavioral health treatment they need. Implementation and enforcement of parity laws have been uneven, health plans and payers continue to fall short of providing parity, many people still aren’t aware of their parity rights, and too many seeking behavioral health treatment continue to face visit limits, higher out of pocket costs and stricter rules on how care is reviewed than for medical and surgical benefits.

FEDERAL & **STATE PARITY LAWS**

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
Congress passed MHPAEA, the federal parity law, to ensure equal coverage of treatment for mental health and addiction across most—but not all—health insurance plans. MHPAEA requires that health plans offering mental health or substance use disorder benefits apply rules and limits that are equal to or less restrictive than for physical health benefits.

Patient Protection and Affordable Care Act of 2010 (ACA)
In addition to mandating state health insurance exchanges and authorizing Medicaid expansion, the ACA strengthens parity through:

- Consumer protections: Health plans can't turn people down or charge more for having major illnesses such as mental health or substance use conditions. The law does not allow lifetime or annual treatment limits. Parents can include adult children on their health plan up to age 26.
- Parity in individual and small group plans: Requires all individual and small group health plans to meet MHPAEA parity requirements whether they are sold through an exchange. Requires parity in private health plans that cover people in Medicaid expansion and Children's Health Insurance Plans (CHIP).
- Essential Health Benefits: All individual and small group plans must cover 10 Essential Health Benefits (EHB). Behavioral health is one EHB category. EHBs must meet parity standards, not only within the 'behavioral health' category, but also in other categories such as emergency care.

21st Century Cures Act (2016)
With continued ambiguity around how health plans should measure parity and how regulators should hold them accountable, Congress addressed these issues and included them in the broader 21st Century Cures Act. Key components:

- Plan guidance: Departments responsible for parity enforcement must issue a compliance program with specific examples of compliance and non-compliance and better definitions of non-quantifiable treatment limits. This compliance plan will be updated every two years.
- Improved federal/state parity enforcement: The U.S. Department of Health and Human Services is required to produce an action plan to improve state and federal coordination on parity compliance.
- Annual report on parity complaints: The departments must submit reports to Congress on closed investigations into parity violations.
- Government Accountability Office (GAO) study: The GAO was required to submit a study that outlines how health plans are complying with the law.
- Enforcement: If a plan is found to have violated parity laws five times, it triggers a federal audit.
- Eating disorder treatment: Plans that cover treatment for eating disorders must offer benefits as they would for other mental health conditions. This law also provided resources for more public awareness programs and model interventions for eating disorders.

Tennessee Public Chapter 1012 (2018)
Passed by Tennessee lawmakers, this bill aligns state law with more recent federal parity laws and required the state Department of Commerce & Insurance to issue a report to lawmakers on its efforts to enforce parity laws.

Consolidated Appropriations Act (2021)
This Act focused on issues related to the COVID-19 pandemic, but a portion addressed parity. It requires health plans to prove in writing how they apply NQTLs (prior authorization, medical necessity standards, etc.) to mental health and substance use disorders as they do for medical/surgical benefits. Health plans must file reports annually with departments outlining how they comply with the parity law.

Tennessee Public Chapter 244 (2021)
Lawmakers in Tennessee passed legislation requiring the state Department of Commerce & Insurance to obtain the reports filed at the federal level under the Consolidated Appropriations Act and provide an annual report to the Tennessee Legislature regarding ongoing efforts to enforce parity laws.

Federal Rules (2024)
The U.S. Departments of Labor, Health & Human Services, and Treasury finalized new rules requiring plans to provide substantial treatment options across all benefit classifications where medical/surgical benefits are offered. The rules require the use of current medical standards for defining mental health/SUD conditions and include non-federal self-governed plans on the list of plans that must now follow federal parity laws. The rules have been challenged by the insurance industry and the Trump administration in early 2025 froze them.

HEALTH PLANS AND **FEDERAL PARITY**

Not all types of health coverage must meet parity requirements, and conditions under which parity applies vary. The following chart shows the types of health plans that must comply with federal parity law.

Type of Plan	Parity?	Notes
Employer Sponsored		
Large employer >50 employees	**Yes**	Not required to provide mental health or addiction benefits, but if they do, coverage must be on par with other medical benefits.
Small employer, fully-insured 2 to 50 employees	**Yes**	Must provide mental health benefits and required to follow federal parity law. Fully insured means an employer purchases a plan from another company and may pay part of the premium.
Small employer, self-insured 2 to 50 employees	**No**	Self-insured means an employer fully funds a plan but may contract with another company to use their network and manage claims.
Federal Employee Health Benefits Plan (FEHB)	**Yes**	Must provide mental health benefits; required to follow federal parity law.
Non-federal government	**Yes**	New rules adopted under the Biden administration in 2024 no longer allow health plans for state or local government workers to opt out of federal parity law.
Faith-based organizations	**No**	Plans for employees of faith-based organizations can opt out of federal parity law.
Retiree only	**No**	Plans that only cover retirees can opt out of federal parity law.

Government Programs		
Medicare	**No**	Federal health plan for people who are age 65 or older and people with disabilities.
Children's Health Insurance Program (CHIP)	**Yes**	Government health plan for low to middle income children. Federal parity law applies.
Medicaid, managed care (TennCare)	**Yes**	Government health plan for certain low-income children, adults, and individuals with disabilities.
Medicaid, fee-for-service	**No**	Federal parity law applies to Medicaid managed care plans, but not fee-for-service plans.
TRICARE	**No**	Federal health care program for uniformed military service members and their families
Individual Plans		
Individual health plans1 (You buy for self or family)	**Yes**	Must provide mental health benefits; required to follow federal parity law.

1 Per SAMHSA, "'Grandfathered' generally means that coverage for those plans was already in effect on March 23, 2010, and that this coverage that has not made certain changes to cost-sharing or benefits since then." Such plans are not required to comply with federal parity law.

PARITY **PROTECTIONS**

Parity law applies to the following types of care, costs, and limits:

Types of care

- Hospital or residential treatment-resistant
- Outpatient visits
- Emergency or crisis care
- Prescription drugs
- Both in-network and out-of-network

Out-of-Pocket Costs: *The following costs for mental health and substance use disorder treatment benefits cannot be greater than costs for comparable physical health care*

- Copays: Flat fee per visit or service
- Coinsurance: Percentage of total service cost
- Maximum out-of-pocket costs: What you pay before the plan pays 100%
- Deductibles: What you pay before the plan begins to pay
- Annual or lifetime dollar limits: The most a plan will pay in a year or lifetime

Treatment Limits: *The following limits to mental health and substance use disorder treatment benefits cannot be more restrictive than limits for comparable physical health care*

- Number of outpatient visits
- Number of days in hospital or residential care
- Limits on prescription medications
- Excluded types of treatment or situations

Other Limits: *The following limits to mental health and substance use disorder treatment benefits cannot be more restrictive than limits for comparable physical health care*

- Prescription drug costs or requirements
- Prior-approval requirements
- Clinical standards used to approve or deny care
- Availability of providers

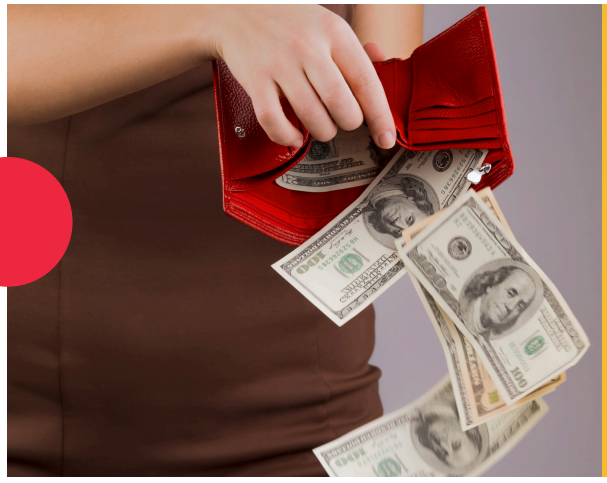
PARITY VIOLATION: **WARNING SIGNS**

Fewer visits or days covered

Warning sign: The health plan covers fewer office visits or inpatient days for mental health or substance use disorder treatment than for comparable physical health care.

Residential or partial hospitalization care not covered

Warning sign: The health plan does not cover residential treatment or partial hospitalization for mental health or substance use disorder treatment, but similar care is covered for other medical conditions.



Higher out of pocket costs

Warning sign: The health plan charges more for mental health and substance use disorder care:

- Added deductible for mental health and substance abuse care
- Higher copay for services (set fee per visit or prescription)
- Higher coinsurance (percentage of total cost)
- Medication or treatment placed on a higher tier (percentage of total cost)

PARITY VIOLATION: **WARNING SIGNS**

Care denied unequally as not being medically necessary

Warning sign: The health plan reviews requests for mental health or addiction treatment more often or in a stricter way than for other types of care. Health plans approve or deny requests for care based on medical necessity. A treatment request may be denied because:

·It is not approved for certain health conditions
·The treatment may only work under certain conditions
·Effectiveness or safety may be in question
·The cost is higher than other types of care for the same condition

Having to ask for special permission more frequently

Warning sign: *The health plan requires prior approval more often for mental health and substance use disorder treatment than other types of care.*

With prior authorization or prior approval (PA) the member or provider must contact the health plan to ask permission before starting treatment. If PA is granted, the plan will pay.

Step therapy is a type of prior authorization in which the member must try a more common, often less expensive, treatment or medication before they can "step" to the treatment prescribed by the provider.

Cannot find in-network providers

Warning sign: It is hard to find local mental health or substance use disorder treatment providers in the health plan network, but other types are available. Provider directory is not up to date.

To keep premiums low, health plans contract with a limited number of providers who meet quality standards. In return for client referrals, providers go through a review process, agree to work for a reduced rate, and follow plan procedures. This is called a provider network.

COMPLAINTS & **APPEALS**

When care is denied or another parity warning sign is identified, a health plan member or provider has the right to file a complaint (about the quality of care or coverage) or to 'appeal' (ask for a different decision). Complaints and appeals are a standard part of the insurance business. Complaints and appeals help state and federal oversight agencies identify potential parity violations and enforcement opportunities.

How to prepare a complaint:

- Health plan member and provider discuss the reason for the complaint or appeal. Write down the details.
- Member or provider contacts the health plan customer service office to ask for a different decision.
- If not resolved, the member or provider files a written complaint with the health plan.
- At the same time, the member or provider contacts the appropriate state or federal health insurance department to file a complaint or obtain more information about parity or the complaint process. Please see the chart below to determine which insurance department should handle the complaint.

Filing a complaint:

1. Complete this complaint form https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-4591
2. Submit the completed complaint form online, if able. Options to submit the complaint by physical mail or fax are listed on the form.
3. Call 800-342-4029 if you need assistance in completing or submitting the complaint form.

What happens after a complaint is filed?

1. When the state or federal insurance department receives the form, you will receive written notice that your complaint has been received. A file number will be assigned which you should use any time you contact them about your complaint.
2. If submitted to the appropriate insurance department, they will forward the complaint to the health insurance company or agent, which must respond within 30 days.
3. When the insurance department receives a response one of the following will happen:

a. If the complaint has been resolved, the file will be closed. You should get a letter.

b. If an insurance law has been violated, the health insurance company will be asked to correct the problem. The complaint will be referred to the legal department for further action.

c. If the company is not abiding by the policy, this will be brought to their attention and, if not corrected, the complaint will be referred to the legal department for further action.

d. If the insurer or agent has not responded to all questions or has not looked into the complaint in detail, they will be required to do so.

e. If no violation is found, you will get a letter explaining this and offering other options if any are available. The complaint file will remain open for 10 days to allow time for a rebuttal if needed.

4. It takes approximately 45 days to complete this process from the time a complaint is received to when the problem is solved. A complex complaint could take longer.

Type of Health Plan	Agency	Make a Complaint	More Details
Employer based, including large group and self-insured health plans	U.S. Department of Labor, Employee Benefits Security Administration (EBSA)	Parity complaints for self-insured, private employer health plans are made by calling 866-444-3272	For information visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/understanding-parity-a-guide-to-resources-for-families-and-caregivers
Fully insured employer plans (large and small groups) and individual/family plans in Tennessee	Tennessee Department of Commerce & Insurance	https://access.cloud.commerce.tn.gov/portal/public/information/complaint	You can call the Insurance Division at (800) 342-4029 and press 2, or email CIS.Complaints@state.tn.us. 800-342-402
Medicaid Managed Care or Children's Health Insurance Plan (CHIP)	State Medicaid Program (TennCare)	Appeal a TennCare decision here https://www.tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html	For more information, call 615-741-2677 or reach the TennCare Hotline at 866-311-4287. https://www.tn.gov/content/dam/tn/tenncare/documents2/MentalHealthParity.pdf
Federal Employee Health Benefit plan (FEHB)	U.S. Office of Personnel Management	Submit complaint by email (no form required): FEHB@opm.gov	For more info, call 202-606-1800 or visit: https://www.hhs.gov/mental-health-and-addiction-insurance-help.
State/local government employee self-funded plan	U.S. Department of Health & Human Services	https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-4591	For more information, email NonFed@cms.hhs.gov or visit: https://www.hhs.gov/mental-health-and-addiction-insurance-help.

Not sure where to file?

If uncertain how file a complaint or appeal, contact the TN Department of Commerce & Insurance: https://www.tn.gov/commerce/insurance/consumer-resources/file-a-complaint.html

You can also visit the federal HHS parity complaint website for more information: https://www.hhs.gov/mental-health-and-addiction-insurance-help

For additional resources and helpful information, visit the Tennessee Parity Project website: https://tnparityproject.org/

SAMPLE INSURANCE COMPLAINT FORM

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Required fields are marked with an asterisk*
Please note: Entry of accented characters such as é, ä and ñ, are not supported in this form.

Complainant's information:

* First name | Middle | *Last name

*Address

*City | *State | *ZIP

County | Country | International ZIP

Email address:

Please re-enter email address as verification:

*Phone number: | Extension:

*Alternate phone number: | Extension:

How do you want to be contacted?

Insured Information (if different than above)

* First name | Middle | *Last name

Other parties involved in this problem:

* First name | Middle | *Last name

***Type of Insurance**

- Annuity
- Auto
- Commercial
- Dental
- Disability
- Group health
- Home
- Individual
- Life
- Long term care
- Medicare supplement
- Other
- Title
- Workers comp

***Reason for Complaint** check one or use ctrl key to make multiple selections

- Agent handling
- Cancellation
- Claim delay
- Claim denial
- Delays/no response
- Information requested
- Misrepresentation
- Nonrenewal
- Other
- Premium & rating
- Premium notice/billing
- Premium refund
- Unsatisfactory settlement offer

Other desc. | Other desc.

***Details of complaint**

***What do you consider to be a fair resolution?**

Maximum fair resolution length: 4,000 characters. Characters left:

Note: After the final submission of this form, you will be provided an opportunity to attach supporting documents.
Will you be mailing or attaching additional supporting information?

RESOURCES

Tennessee Government Resources
Department of Commerce & Insurance: State insurance agency staffed to answer insurance questions and assist with complaints and/or appeals. Consumer Affairs: 615-741-2218; or email CIS.Complaints@state.tn.us For more information or to file a complaint visit the online portal at https://www.tn.gov/commerce/insurance/consumer-resources/file-a-complaint.html
TennCare: Tennessee's Medicaid managed care program Complaints and Appeals: 800-878-3192 https://www.tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html
Department of Mental Health and Substance Abuse Services: State agency responsible for mental health and substance use disorder services. Help Line: 800-560-5767 Information & Referral, M-F, 8:00am – 4:30pm

Federal Resources

U.S. Department of Health and Human Services (HHS)
Parity Portal Website to file parity complaints and appeals with the correct government agency.

- https://www.hhs.gov/mental-health-and-addiction-insurance-help

U.S. Department of Labor (DOL)
Employee Benefits Security Administration (EBSA): Federal agency responsible for employer sponsored and large self-insured health plans.

- 866-444-3272
- https://dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
- https://www.dol.gov/general/topic/health-plans/consumerinfhealth

Centers for Medicare and Medicaid Services:
Federal agency responsible for Medicare, Medicaid and health insurance exchange or federal Marketplace health plans.

- Helpline: 800-985-3059
- https://www.cms.gov/medical-bill-rights/help/submit-a-complaint
- For Healthcare.gov marketplace plan complaints: https://www.healthcare.gov/appeal-insurance-company-decision/

Substance Abuse and Mental Health Services Administration:
Federal agency responsible for mental health and substance use services.

- https://library.samhsa.gov/product/know-your-rights-parity-mental-health-and-substance-use-disorder-benefits/pep21-05-00-003
- Helpline: 800-662-4357

Advocacy Organizations
The Kennedy Forum unites mental health advocates, business leaders, and government agencies around a common set of principles, including full implementation of the Federal Parity Law. Visit https://www.thekennedyforum.org/focus-areas/coverage-parity/parity/
Mental Health America addresses the needs of people with mental illness and promotes the mental health of all Americans. Visit https://mhanational.org/resources/how-to-overturn-managed-care-treatment-denials/
National Alliance on Mental Illness (NAMI) is an organization of individuals and families affected by mental health conditions. Provides support, education, advocacy, and awareness. Helpline: 1-800-950-6264, or email info@nami.org Parity information: https://www.NAMI.org/parity
ParityTrack Helps people with mental health and substance use disorders understand and exercise their rights under parity law. https://www.paritytrack.org
Tennessee Parity Project Coalition of behavioral health advocates, providers, and those with lived experience working statewide for fairness and equity in mental health and substance abuse services. https://www.tnparityproject.org

GLOSSARY

Appeal: If a health plan will not pay a claim or drops a member from coverage, the member has the right to appeal for a different decision and have it reviewed by a third party. Insurers must explain why the claim has been denied or coverage has been dropped.

Children's Health Insurance Program (CHIP): CHIP provides health coverage for eligible children, through both Medicaid and separate CHIP programs. CHIP is funded with federal and state dollars and operated by states under federal rules

Coinsurance: The health plan member shares the cost of a covered service. Coinsurance is a percentage (for example, 20%) of the allowed cost of service. For example, if the allowed amount for an office visit is $100 and the member has met the deductible, the coinsurance payment of 20% would be $20. The health plan pays the remaining allowed amount.

Complaint: If a health plan member has reason to believe that the plan is not providing benefits as required in the health plan policy or the law, the member can file a complaint with the health plan or the state of federal government agency in charge the plan.

Consumer protections: Health care law offers rights and protections that make coverage more fair and easy to understand. Some protections may apply to plans in the Health Insurance Marketplace, other individual plans, job-based plans, and some apply to all health coverage.

Copayment, copay: A fixed amount (Example: $20) the health plan member pays for a covered service, usually at the time of service. The amount can vary by the type of covered health care service.

Credentialing: The process of deciding whether a professional will be included in a health plan network. The health plan usually reviews education, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence.

Deductible: How much the member owes for covered health care services before the health insurance begins to pay. The deductible does not apply to preventive services such as annual check-ups or mental health screening, meaning that the plan will pay even before the deductible has been met.

Essential Health Benefits (EHB): Under the Patient Protection and Affordable Care Act, all individual and small group health plans (except grandfathered plans) must cover 10 types of care: (1) outpatient services; (2) emergency services; (3) hospital care; (4) maternity and newborn care; (5) behavioral health services; (6) prescription drugs; (7) rehabilitation; (8) lab services; (9) preventive and wellness services; and (10) children's services, including dental and vision. All EHB must comply with federal parity law.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a preferred drug list (PDL).

Grandfathered health plan: Health plans that existed on March 23, 2010, and haven't cut benefits or increased member costs. Grandfathered plans do not have to offer parity or other protections required under the Affordable Care Act. Insurance companies must notify members who have grandfathered plans.

Individual health plan: Health coverage purchased by an individual for self or family either through a health insurance exchange, or directly from the health insurance company.

Medical necessity, medically necessary: Health care services or supplies needed to prevent, diagnose, or treat a condition, and that meet accepted standards of medicine

Narrow network: To lower costs, health plans contract with a limited number of service providers, hospitals, labs, and pharmacies. The monthly premium may be lower, but members pay more if they use out-of-network care.

Out of pocket cost (OOP): The amount owed by a health plan member during a policy period before the health insurance plan begins to pay 100% of the allowed amount. This limit does not include the premium, balance-billed charges or costs for benefits not covered under the plan.

Parity (Mental Health and Addiction): Most health insurance plans are legally required to cover mental health and addiction treatment at the same level as other types of medical care.

Provider Network: Facilities, providers and suppliers contracted with a health plan to provide care to members. The health plan covers more of the cost of care for in-network providers. However, for a given type of care, if no in-network provider is available within a certain distance from the member's home, the health plan is required to pay for an out of network provider.

Prior authorization, prior approval (PA): A decision by the health plan that a health care service, treatment plan or prescription drug is medically necessary. Sometimes called preauthorization, prior approval, or pre-certification.

Medically necessary, medical necessity: Health care services or supplies needed to prevent, diagnose, or treat an illness or condition and that meet accepted standards of medicine.

Non-quantitative treatment limits (NQTL): Standards used to review treatment requests for type and duration of care that do not involve numbers of visits or days. NQTLs include prior approval, step therapy and other techniques to decide whether a service is medically necessary. Under the ACA, an NQTL must not limit mental health or addiction treatment more than medical or surgical care.

Quantitative treatment limits (QTL): Standards that limit the type or duration of benefits that involve a number of visits, days, or costs. Examples include the number of visits or inpatient days, copays, coinsurance, or annual dollar limits. Under the Patient Protection and Affordable Care Act (ACA), QTL must be no more restrictive for mental health or substance use care than for medical surgical care.

Self-insured/self-funded health plan: A health plan in which the employer assumes the financial risk for providing health care benefits to its employees.

Small group health plan: Employer-sponsored health insurance offered by an employer with 2 to 50 employees.

Step therapy, fail first: A type of prior approval in which the member must try and fail to respond to certain treatments that are less expensive, but effective for most people with a given condition, before they can "step" to a different treatment. For example, the plan may require a generic drug, then a less expensive brand-name drug from its formulary, before covering a similar, more expensive brand-name prescription drug.

Substantially all: If a type of cost requirement or treatment limit applies to substantially all medical/surgical benefits in a class, then that requirement or limit may apply to mental health or substance use disorder benefits if it is on par with two-thirds or more of the medical/surgical benefits for the same class of treatment.

Tier: A level of health coverage for a given type of care. For example, health plan members would pay more out of pocket costs for a prescription drug on tier 3 than for a medication on tier 1.

Utilization management (UM): Array of procedures used by insurers to evaluate whether requested care is medically necessary, efficient and in line with accepted medical practice.