



Know your Rights, Understand your Coverage!

October, 2019

Regardless of whether or not you have insurance, or what type of insurance you have, it's important to know your rights when it comes to mental health coverage. This document will provide some helpful information to help you understand and advocate for your health care rights.

No matter who your insurance provider is...

Under the **Mental Health Parity and Addiction Equity Act of 2008**, most health plans are required to offer the same benefits for mental health services that they do for physical health services (often referred to as "medical/surgical benefits" by insurance companies). **This means that mental health benefits must be equal to those offered for physical health services.**

Examples of benefits that must be equal include:

- Copayments (or "copays")
- Deductibles
- Yearly visit limits
- Need for prior authorization
- Proof of medical necessity

Your insurance provider must inform you of what benefits it does and does not cover, and you have the right to request information about this. **The Parity Act applies to all employer-sponsored health coverage, coverage purchased through health insurance exchanges, Children's Health Insurance Programs (CHIP), and most Medicaid programs.**

PLEASE NOTE: The law does not require insurance companies to provide mental health care coverage. Instead, it states that if they do offer mental health care coverage, it must be on the same level as the physical health care coverage.

The **Patient Protection and Affordable Care Act of 2010** (commonly referred to as "the Affordable Care Act," or "the ACA") further expanded upon the Parity Act in the following ways:

- Naming mental health services as "Essential Health Benefits," and thus making them required coverage elements of any plan in the ACA's health insurance marketplace (including individual and small group markets).
- Requiring most plans to cover preventive services, such as mental health screenings and assessments, at no additional cost.
- Mandating that insurance companies could no longer deny coverage for pre-existing conditions, including mental health conditions.

To fully understand your insurance coverage, ask for a "Summary of Benefits and Coverage" from your employer's HR department and/or your insurance provider directly.

If you have Medicaid/Children's Health Insurance Program...

All state Medicaid programs provide some degree of mental health services to adults. This falls under the ACA's expansion of coverage for "Essential Health Benefits," which includes mental health services. Per the Parity Act, Medicaid must offer mental health benefits that are equal to those offered for physical health services.

Youth covered by Medicaid/the Children's Health Insurance Program (CHIP) receive full coverage for mental health services, such as therapy, medication, hospitalization, and case management.

PLEASE NOTE: Medicaid and CHIP coverage varies by state — for more information about what your state covers, please visit medicaid.gov/medicaid/benefits/bhs (Medicaid) and medicaid.gov/chip/benefits (CHIP).

If you have Medicare...

Various mental health services are covered under the separate "parts" of Medicare.

- Part A provides hospital insurance, including inpatient/residential mental health care.
- Part B provides medical insurance, including outpatient mental health care (such as visits with a therapist, psychiatrist, etc.).
- Part D provides drug insurance, including prescriptions to treat your mental health condition(s). Exact drugs covered vary by plan, more information about what is and is not covered under yours can be found at medicare.gov/part-d/coverage/part-d-coverage.html

For more information about your Medicare coverage, visit medicare.gov/Pubs/pdf/10184-Medicare-and-Your-Mental-Health-Benefits.pdf

If you need to go outside of your insurance coverage...

- If you are unable to receive mental healthcare from someone who accepts your insurance plan, there are a few options that may be available to you to get back some of your treatment costs.
 1. If you participate in a Flexible Spending Account (FSA) or Health Savings Account (HSA) through your insurance, you may be able to use those funds to pay for your treatment. Find out what the requirements for this might be from your insurance plan, and work with your treatment provider(s) to get the necessary documentation.
 2. Check whether or not your insurance plan provides coverage for "out of network providers." If so, you may be able to submit a claim for treatment received from these out of network providers and receive partial or full reimbursement for what you paid out of pocket.
- To see if these options might be possibilities for you, ask your employer's HR department or contact your insurance plan directly.

If you are uninsured...

- If you do not currently have insurance, note that the open enrollment period for 2019 has passed. You may still be eligible to apply for 2019 coverage if you qualify for a Special Enrollment Period due to a qualifying life event (such as having a baby, getting married, or losing previous coverage), or if you are eligible to apply for Medicaid or CHIP. To learn more about your options and sign up, please visit [healthcare.gov](https://www.healthcare.gov). Open enrollment to get coverage for 2020 runs from November 1, 2019 through December 15, 2019.

RESOURCES:

- FAQ about mental health coverage by the US Department of Health and Human Services: [mentalhealth.gov/get-help/health-insurance](https://www.mentalhealth.gov/get-help/health-insurance)
- Information about mental health services under the new health care laws: [healthcare.gov/coverage/mental-health-substance-abuse-coverage/](https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/)
- American Psychological Association's (APA) Parity Guide: [apa.org/helpcenter/parity-guide.pdf](https://www.apa.org/helpcenter/parity-guide.pdf)
- Information about state-specific, non-Medicaid insurance coverage: [naic.org/state_web_map.htm](https://www.naic.org/state_web_map.htm)



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