Mental Health Parity



Alternatives to enforcing patient rights to mental health care through private insurance.

BY JOSEPH FELDMAN & MARK DeBOFSKY

FOR MANY YEARS, IMPROVING ACCESS TO MENTAL HEALTH CARE HAS BEEN a public policy objective secured through legislation and regulation of health insurers' clinical provider networks, coverage determinations, and so-called "parity" with physical health claims. Recent federal and state laws (especially in Illinois) have increased the obligations placed on insurers and have mitigated certain practices such as quantitative limitations on visits to clinicians and "fail first" requirements blocking immediate access to more effective levels of care. Yet, enforcement remains difficult: Regulators are often slow to act, and patients who challenge claim denials in court face daunting odds.

Individuals and families who depend on their insurers to cover necessary care are well-advised before embarking on costly litigation to consider more accessible, faster steps to hold insurers

ISBA RESOURCES >>

- Jennifer M. Danish, *Understanding the Illinois DOI's External Review Process: A Guide for Attorneys*, The Policy (Feb. 2025), law.isba.org/4Ayq3ns.
- Joseph T. Monahan & Matthew R. Davison, *Mind Over Matter*, 112 Ill. B.J. 30 (Nov. 2024), law.isba.org/4dUWeDK.
- Jeremy M. Pelphrey, *Interim Final Regulations Issued for Health Plans for Internal Claims, Appeals, and External Review*, Employee Benefits (Sept. 2010), law.isba.org/3VbRnru.

accountable for their legal obligations. Such actions include submission of clinicians' detailed documentation of medical necessity, formal insurer complaints, legislator support requests, and regulatory complaints. Given the prevalence of mental health insurance-coverage challenges, these steps can be effectively utilized by lawyers keen to offer their clients concrete support when approached for guidance.

Limitations of litigation

The passage of laws, such as the federal Mental Health Parity and Addiction Equity Act of 2008,[1] the Illinois Healthcare Protection Act of 2024,[2] and numerous additional state laws, provides a foundation for insurer accountability vis-à-vis mental health care. Nevertheless, the full intent of these laws has yet to be realized.

In an email to one of the coauthors, a health insurance executive reported that the "federal passage of the [Mental Health Parity and Addiction Equity Act] went a long way to make sure [mental health benefits] are at least on par with medical benefits. There is still a lot of wiggle room as medical benefits aren't bucketed the same as mental health benefits are."[3]

Notwithstanding such laws, the potential of litigation to empower patients to dispute health insurance actions is substantially limited mostly due to the pervasive impact of the Employee Retirement Income Security Act (ERISA)[4] and the absence of meaningful "bad faith" insurance law.[5]

ERISA[6] governs group health insurance benefits provided



JOSEPH FELDMAN, *MBA, is president and founder of Cover My Mental Health and began advocating for access to mental health care after overcoming denials for his adolescent's residential care, including with a successful federal lawsuit.*

joe@covermymentalhealth.com



MARK DeBOFSKY *is a member of the firm of DeBofsky Law Ltd. in Chicago and has been a patient advocate throughout his career.*

mdebofsky@debofsky.com

TAKEAWAYS >>

- Federal parity law and Illinois' Healthcare Protection Act have expanded insurers' obligations and curbed visit limits and fail-first rules, but enforcement lags and litigation remains difficult.
- Attorneys can help clients get detailed medical necessity letters, document failed network searches, file formal insurer complaints, enlist legislators' constituent-services offices, and request independent external review.
- Clients should take these steps alongside internal appeals, not instead of them, so they don't waive appeal rights. Formal complaints and external review can resolve disputes faster and more cheaply than litigation.

1. 42 U.S.C. § 300gg-26 (Public Health Service Act); 29 U.S.C. § 1185a (Employee Retirement Income Security Act); 26 U.S.C. § 9812 (Internal Revenue Code); see also 45 C.F.R. § 146.136; 29 C.F.R. § 2590.712; 26 C.F.R. § 54.9812-1.
2. Pub. Act 103-650 (eff. Jan. 1, 2025); 215 ILCS 5/370c.1; 215 ILCS 5/370c; 215 ILCS 5/356z.14 (mandate for coverage of autism spectrum disorders). Certain changes to the Managed Care Reform and Patient Rights Act took effect Jan. 1, 2026.
3. Email from health insurance executive to Feldman on Mar. 11, 2025 (on file with authors).
4. 29 U.S.C. § 1001 *et seq*.
5. See, *e.g.*, 215 ILCS 5/155 (limiting extracontractual damages).
6. 29 U.S.C. § 1001 *et seq*.

THE POTENTIAL OF LITIGATION TO EMPOWER PATIENTS TO DISPUTE HEALTH INSURANCE ACTIONS IS SUBSTANTIALLY LIMITED MOSTLY DUE TO THE PERVASIVE IMPACT OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT AND THE ABSENCE OF MEANINGFUL "BAD FAITH" INSURANCE LAW.

by private sector employers, who cover nearly half of all Americans.[7] ERISA prevents plaintiffs from recovering punitive or emotional distress damages, regardless of whether the insurer acted fraudulently.[8] A successful lawsuit is generally limited to recovering the denied benefit itself, and the awarding of legal fees is left to the judge's discretion and the degree of success on the merits.[9] Discovery and introduction of evidence are also limited.[10] State laws regulating insurance are exempt from the broad sweep of ERISA preemption,[11] but self-funded plans are exempt from state insurance regulation.[12]

Another key obstacle faced by patients challenging coverage denials is the standard of judicial review applied by the courts. Language in plans reserving discretion to determine benefit eligibility triggers a deferential standard of judicial review.[13] Under that standard, even erroneous claim determinations will be upheld so long as they are found reasonable.[14] While the State of Illinois has banned the inclusion of discretion-granting language in health and disability insurance policies,[15] the regulation is inapplicable to self-funded health plans and plans delivered out of state. These factors result in a limited number of attorneys willing to pursue such disputes.

For disputes with Medicaid, Medicare, and other government-provided insurance, litigation is similarly limited for individuals, and, likewise, few lawyers are willing to tackle such claims.

Class actions offer a path for substantive policy change, but such litigation is often lengthy and costly. Moreover, in one of the most successful class actions brought to challenge systemic denials of mental health claims, *Wit v. United Behavioral Health,*[16] the plaintiffs' sweeping victory was mostly overturned on appeal.[17] Further, in most situations it is difficult to obtain class action certification since varying medical conditions and other factors defeat the commonality of the claims brought.

In most instances, the primary means of addressing a claim denial is for the patient to file an appeal. For most claims governed by ERISA, claim appeals are mandatory based on an ERISA statutory provision that entitles claimants to a "full and fair review" of the denial.[18] A detailed set of regulations[19] promulgated by the U.S. Department of Labor, which has primary jurisdiction over ERISA, lists the elements that encompass the meaning of full and fair review.

However, other steps also may be effective—although claimants should take care not to waive their appeal rights and should pursue such steps in conjunction with an appeal.

Nonlitigation, nonappeal actions

Certain contractual obligations placed on health insurers and plan administrators provide potential avenues for patients and clinicians to enforce coverage of mental health care. Specifically:

- Health insurance contracts specify their obligation to cover "medically necessary" care[20] as the scope of insurers' accountability.
- Health insurance contracts and benefit plan documents presume an obligation that members will receive timely, nearby access to suitably competent clinicians who can provide that medically necessary care.

From the patient's perspective, the decision as to what care is "medically necessary" is made by the treating clinician whose training, experience, and application of generally accepted relevant standards of care inform their treatment. An insurer may use some other basis, for example a proprietary, undisclosed guideline, resulting in a denial of care or an attempt to impose a lesser level of care, which was the subject of the *Wit* litigation.

Detailed medical necessity letters setting forth the clinical rationale for the recommended treatment are needed to provide essential advocacy supporting the appropriate course of treatment and document the competence of the clinician prescribing the course of treatment. As described in our 2021 article[21] in the Journal of Psychiatric Practice, medical necessity letters provide essential documentation that prescribed treatment is medically necessary and qualifies for insurance coverage.

Patients and clinicians have successfully used medical necessity letters to overcome obstacles to insurance approval, including:

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7. *2021 Employer Health Benefits Survey*, Kaiser Fam. Found. (Nov. 10, 2021), law.isba.org/4rurpeN.
8. See *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding that ERISA remedies are limited and that ERISA preempts state common-law bad-faith claims).
9. 29 U.S.C. § 1132(g); *Hardt v. Reliance Standard Life Insurance Co.*, 560 U.S. 242, 255 (2010) (quoting *Ruckelshaus v. Sierra Club*, 463 U.S. 680, 694 (1983)).
10. See, *e.g.*, *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir. 1999) (limiting evidence in ERISA lawsuits to the "administrative record," *i.e.*, the insurance company's claim file).
11. 29 U.S.C. § 1144(b)(2)(A).
12. 29 U.S.C. § 1144(b)(2)(B).
13. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).
14. See *Holmstrom v. Metropolitan Life Insurance Co.*, 615 F.3d 758 (7th Cir. 2010) (defining "reasonableness").
15. 50 Ill. Adm. Code § 2001.3.
16. *Wit v. United Behavioral Health*, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).
17. *Wit v. United Behavioral Health*, 58 F.4th 1080 (9th Cir. 2023).
18. 29 U.S.C. § 1133.
19. 29 C.F.R. § 2560.503-1.
20. Representative language: "Medically necessary means that a specific medical, health care, supply, or hospital service is required, for the treatment or management of a medical symptom or condition and that the service, supply, or care provided is the most efficient and economical service which can be safely provided."
21. Joseph Feldman, Mark DeBofsky, Eric M. Plakun & Cheryl Potts, *Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients*, 27 J. Psychiatric Prac. 288 (2021).

- residential treatment of substance-use disorders and other chronic conditions that cannot be effectively treated otherwise;
- long-acting injectable medication (when oral dosing failed);
- transdermal medication (when oral dosing failed); and
- access to outpatient care with sufficient frequency.

Insurance networks that lack sufficient clinicians to treat mental health conditions have drawn the attention of legislators[22] and journalists.[23] So-called "ghost networks" often include clinicians who are not taking new patients, whose schedules preclude near-term appointments, whose expertise is not specified in the directory, who left the network, or who never were in the network.

In 2022 and 2023, the Illinois Department of Insurance fined Health Care Service Corporation, the parent company of Blue Cross Blue Shield of Illinois, for failing to notify the agency that a major health care system (Springfield Clinic) had been removed as an in-network provider and later for failing to provide accurate provider directories. The initial fine was the first issued under the Network Adequacy and Transparency Act.[24]

Illinois legislators took additional action to address ghost networks by passing the Healthcare Protection Act in 2024,[25] which—among many other novel protections—established standards for appointment-time availability and requirements to ensure sufficient numbers of in-network doctors so that patients can locate care in their area and have a transparent view of their in-network providers.

Holding health insurers accountable for inadequate networks should begin with a patient (or family member) documenting unsuccessful efforts to locate an appropriate provider within their insurer's network. That is, a patient is accountable for utilizing a directory, so written evidence of their unsuccessful search may prove helpful in holding an insurer accountable. Such accountability may include requesting that the insurer identify an in-network clinician or make an out-of-network clinician available at in-network cost.

While medical necessity letters and documentation of an inadequate network may prompt action by an insurer to allow out-of-network care or reverse a finding of lack of medical necessity, such an outcome is not assured. Nevertheless, that documentation may support a favorable coverage decision with additional efforts described below.

Freedom to operate

Health insurers' freedom to operate depends on their maintaining both accreditation and good standing with state and federal regulators. Those requirements provide potential leverage for individuals encountering obstacles to mental health care and insurance coverage.

Patients and clinicians can file "formal complaints" directly with their health insurers or plan administrators when they encounter obstacles, surprises, and denials of access to care. Such formal insurer complaints are distinct from complaints filed by patients to state or federal regulators and from formal appeals as specified in a health insurance policy.

Formal complaints received by state-regulated health insurers must be recorded and made available to state or federal regulators and to their accreditation body, typically the National Committee for Quality Assurance or URAC (formerly known as the Utilization Review Accreditation Commission).[26] Few individuals are aware of the possibility of making such formal complaints, so their use is relatively unusual. "Formal complaints generally receive elevated attention from insurers due to their reporting and compliance requirements," observed Dana Popish Severinghaus, a former director of the Illinois Department of Insurance and a partner at the firm Noted Advisory. "While this does not guarantee a different outcome, it can lead to a more structured, well-documented, and timely review of the issue."[27]

FROM THE PATIENT'S PERSPECTIVE, THE DECISION AS TO WHAT CARE IS "MEDICALLY NECESSARY" IS MADE BY THE TREATING CLINICIAN WHOSE TRAINING, EXPERIENCE, AND APPLICATION OF GENERALLY ACCEPTED RELEVANT STANDARDS OF CARE INFORM THEIR TREATMENT. AN INSURER MAY USE SOME OTHER BASIS, FOR EXAMPLE A PROPRIETARY, UNDISCLOSED GUIDELINE ….

With a formal insurer complaint, a Texas-based clinic specializing in treatment of obsessive-compulsive disorders resolved a long-festering dispute with an insurer for coverage under a previously agreed, single-case agreement for payments of out-of-network care.[28]

While state and federal insurance regulators have enforcement authority

22. S. Comm. on Finance, *Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks* (May 3, 2023), law.isba.org/4hnZxVc.
23. Max Blau, *State Regulators Know Health Insurance Directories Are Full of Wrong Information. They're Doing Little to Fix It*., ProPublica (Nov. 14, 2024), law.isba.org/4ydLGaX.
24. Peter Hancock, *Lawmakers, Department of Insurance Focus on Blue Cross, Springfield Clinic Controversy*, Capitol News Illinois (Mar. 24, 2022), law.isba.org/4xFQVPB; Press Release, Ill. Dep't of Ins., Pritzker Administration Fines Blue Cross Blue Shield of Illinois $605,000 for Violation of the Network Adequacy and Transparency Act (NATA) (Mar. 9, 2023), law.isba.org/4Ao6zSm.
25. Pub. Act 103-650 (eff. Jan. 1, 2025); 215 ILCS 5/370c.1; 215 ILCS 5/370c; 215 ILCS 5/356z.14.
26. See 215 ILCS 134/50, 134/55 (requiring health care plans to accept and review enrollee complaints and to report complaints and their resolutions to the Department of Insurance annually); Nat'l Comm. for Quality Assurance, Health Plan Accreditation Standards, ME 7 (complaint and appeal policies and procedures).
27. Interview with Dana Popish Severinghaus (Jan. 5, 2026).
28. Single-case agreements are agreements reached with health insurers to provide out-of-network care for the same cost as in-network care on an exception basis.

and welcome individuals filing regulator complaints, a more effective approach may be engaging with state and federal elected officials through their constituent-services offices. Most legislators welcome requests from their constituents who encounter challenges with regulated companies like health insurers because such requests give legislators an opportunity to advocate for citizens in ways that might be more productive than working on a possible legislative solution.

Patients with nongrandfathered health plans, including Affordable Care Act Marketplace plans, also need to be aware of their right to seek an independent external review (in Illinois through the Department of Insurance—except for self-funded plans, which must go through the federal external review process).[29] While seeking such reviews is no guarantee of a successful outcome, a well-supported claim with a detailed letter of medical necessity that references published care standards and peer-reviewed medical literature will often prove convincing. Independent external review also saves time and the cost of legal fees.

Conclusion

While health insurers typically specify internal claim appeals as the one and only available action for members in the event of a dispute, the steps described here provide common-sense approaches when insurers fail to meet their basic obligations. A patient or their attorney need not wait for state or federal regulators to enforce compliance with relevant laws, and dispute resolution need not begin with, let alone require, litigation. IBJ

29. 42 U.S.C. § 300gg-19; 215 ILCS 180.

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