Parity: What to Look For

1. **Look for red flags**. It may be difficult to identify Parity Act[1] violations because providers and consumers of MH/SUD services often have no way of knowing the kinds of restrictions that a health plan imposes on M/S services and do not have plan data needed to determine whether a financial requirement or a treatment limitation is permitted. The following "red flags" are specific examples of common restrictions that raise a possible parity violation and warrant further investigation.

a. **Separate deductibles for MH/SUD and M/S services**. The parity regulations prohibit plans from using a deductible for MH/SUD services that accumulates separately from any deductible for M/S services. Even if the level of the two deductibles is identical, they do not comply with the Parity Act if they accumulate separately. In other words, expenses for MH/SUD and M/S services must accumulate together to satisfy a single "combined deductible." 26 CFR 54.9812-1(c)(3)(v)9A); 29 CFR 2590.712(c)(3)(v)(A); 45 CFR 146.136(c)(3)(v)(A)

b. **Limits on the number of visits or days of MH/SUD treatment**. Some plans apply visit or day limits to MH/SUD services, and those limits are often not applied to M/S services generally. Even if some specific M/S services, like physical or occupational therapy, are subject to these visit limitations, that is not enough to justify limitations on MH/SUD care. The visit limits must apply to at least 2/3 of the M/S benefits to be imposed on MH/SUD services and the level of the limitation on MH/SUD benefits can be no greater than the limit that applies to 51% of M/S benefits. 26 CFR s 54.9812-1(c)(2)(i) and (3); 29 CFR 2590.712(c)(2)(i) and (3); 45 CFR 146.136(c)(2)(i) and (3).

c. **High copayments or coinsurance requirements for MH/SUD treatment**. If a copayment (what you must pay at the time of service) or coinsurance requirement (the percentage that you must pay after the deductible is met) seems unusually high, it may be more restrictive than the requirements applied to M/S services. If the copayment for MH/SUD outpatient visits is the same as the copayment for a M/S "specialist" and higher than the copayment for a primary care physician, the plan must demonstrate that the "specialist" copayment is the predominant value for outpatient visits. 26 CFR 54.9812-1(c)(3)(i)(B).; 29 CFR 2590.712(c)(3)(i)(B); 45 CFR 146.136(c)(3)(i)(B).

d. **Financial requirements for MH/SUD prescription drugs that seem more restrictive than those for M/S prescription drugs**. Plans are permitted to impose different financial requirements on different tiers of prescription drug benefits and still be parity-compliant. But any differences in tier coverage must be based on "reasonable factors" (such as cost, efficiency, and generic versus brand name), not on whether the drugs are generally prescribed for MH/SUD or M/S conditions. 26 CFR 54.9812-1(c)(3)(iii).; 29 CFR 2590.712(c)(3)(iii); 45 CFR 146.136(c)(3)(iii).

e. **Exclusions that seem to apply only to MH/SUD services**. For example, some plans exclude coverage for court-ordered treatment, treatment related to illegal activity or legal charges, or addiction services that are not "voluntary." Because the kinds of treatment

[1] Mental Health Parity and Addiction Equity Act of 2008

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affected are almost exclusively MH/SUD services, plans applying these exclusions are very likely in violation of the Parity Act. 78 FR 68240, 68246 Sec. II C.3.-Preamble.

f. "**Fail-first" or "step therapy" requirements for MH/SUD treatment**. Sometimes, before agreeing to cover a certain level of care or medication, plans will require patients to fail first at less intensive levels of care or less expensive medications. If plans apply these requirements, they must be comparable to and applied no more stringently than those applied to M/S benefits in order to comply with the Parity Act. 26 CFR 54.9812-1(c)(4)(i) and (ii); 29 CFR 2590.712(c)(4)(i) and (ii); 45 CFR 146.136(c)(4)(i) and (ii).

g. **Authorization standards for MH/SUD services (e.g., precertification, concurrent review, treatment plan requirements) that seem especially burdensome**. Plans often apply some authorization standards for all kinds of services. But if they require providers to obtain authorization for MH/SUD services at earlier stages of treatment or with greater frequency (for example, every 5 outpatient visits), or they apply their authorization standards more restrictively to such services, then they are likely in violation. 26 CFR 54.9812-1(c)(4)(i) and (iii) Example 1-3; 29 CFR 2590.712(c)(4)(i) and (iii) Example 1-3; 45 CFR 146.136(c)(4)(i) and (iii) Example 1-3 and 11.

h. **Limitations or exclusions of intermediate levels of care for MH/SUD Benefits (e.g. residential treatment).** The scope of services for MH/SUD benefits must be comparable to the scope of services for M/S. If a plan covers intermediate levels of care for M/S, such as skilled nursing facilities or rehabilitation hospitals, it may not exclude comparable services for MH/SUD care, such as residential treatment. The plan must also cover the intermediate levels of care for MH/SUD in compliance with the QTL and NQTL requirements of the Parity Act (e.g., no more restrictive limitations on the length of stay for MH/SUD benefits than M/S benefits or more stringent authorization standards). 78 Fed. Reg. 68240, 68246 Sec. II. D- Preamble; 26 CFR 54.9812-1(c)(4)(ii)(H) and (iii) Example 9; 29 CFR 2590.712(c)(4)(ii)(H) and (iii) Example 9; 45 CFR 146.136(c)(4)(ii)(H) and (iii) Example 9.

i. **Limitations on location for accessing MH/SUD Benefits**. If a plan limits the geographic location (e.g. must access the benefit from an in-state provider), or the type of facility in which a MH/SUD benefit can be accessed, but does not impose similar restrictions on M/S benefits, a Parity Act violation may exist. For example, a plan cannot deny an enrollee coverage for MH/SUD treatment received out-of-state if it covers M/S benefits in the same classification out-of-state. 26 CFR 54.9812-1(c)(4)(i) and (ii)(H); 29 CFR 2590.712(c)(4)(i) and (ii)(H); 45 CFR 146.136(c)(4)(i) and (ii)(H).

2. **Always Request**

a. the reason for denial and
b. the medical necessity criteria.

Every time that a plan denies a claim for payment or reimbursement for MH/SUD service, or the insurer substitutes a lower level of care than the one requested, you should contact the patient's health plan and request this information (if it has not already been provided). The Parity Act requires insurers to make these disclosures to any plan participant, "contract provider" or beneficiary upon request. You

should request not only the medical necessity criteria for MH/SUD benefits, but also the criteria for comparable M/S benefits, so that the standards can be compared.

3. **Obtain Description of the Patient's Benefits**. To determine if the parity law has been violated, you must compare the standards for MH/SUD with those for M/S benefits within the same classification. You will need a description of both the MH/SUD and M/S benefits under the plan. Persons enrolled in a plan should receive the benefit description and may request this from the plan administrator.

a. 28 26 CFR 54.9812-1(d)(1); 29 CFR 2590.712(d)(1); 45 CFR 146.136(d)(1)

a. Conduct a Comparison. Compare the M/S benefits that are in the same classification as the MH/SUD benefit you are examining. For example, if you are concerned that the plan imposes a higher co-payment for MH/SUD in-network, outpatient benefits than it imposes on M/S benefits, compare the MH/SUD outpatient financial requirements with those placed on M/S in-network, outpatient benefits.

Next Steps

If you think that there may be a potential violation of the Parity Act, you should initiate the insurer's internal grievance process. If you have questions about your rights and protections under the Parity Act, you can contact the Colorado Division of Insurance or file a complaint through their website at Colorado.gov.

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