



Fact Sheet: Parity Red Flags

1. **What do I look for?** It may be hard to identify Parity Act¹ violations. The law and regulations state that access to treatment for behavioral issues should not be more limited than access to treatment for medical issues. In other words, it should be no harder or more expensive to get treatment for behavioral issues than it is to get treatment for medical issues.

However, providers and consumers of mental health and substance use disorder services often have no way of comparing the different kinds of limitations.

The following red flags highlight practices that may indicate a problem. **When this document refers to behavioral services, that includes services for mental health and substance use disorders. When the document refers to medical services, that includes medical and surgical services.**

- a. **I pay a higher copay or coinsurance for behavioral health services.** If the copay or coinsurance is higher for an office visit than what you must pay for medical services, that may violate the Parity Act. All visits to behavioral providers can't automatically be classified as specialist visits either. So, paying specialist costs for a standard visit could signal a problem.
- b. **The number of visits or days of behavioral treatment, inpatient or outpatient, is limited.** If a plan applies visit or day limits to behavioral services, but not to substantially all medical services, that would violate the Parity Act. Limits on just a few medical services, like physical therapy, would not justify broad limits on behavioral treatment.
- c. **There are separate deductibles for behavioral health services and medical services.** The parity regulations prohibit plans from using a deductible for behavioral services that accumulates separately from any deductible for medical services. If there are two deductibles that accumulate separately, that violates the Parity Act even if the level of the two deductibles is identical.
- d. **I can't get the level of behavioral care my doctor says I need, unless I try something less expensive first.** 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. This violates the Parity Act unless that type of requirement is applied similarly to medical benefits.
- e. **The medications I'm prescribed for behavioral health treatment cost more than medications for other kinds of conditions.** Plans are permitted to impose different financial requirements on different tiers of prescription drug benefits and still be parity-compliant. But the use of higher tiers must be "reasonable"—meaning that the decision is based on cost, effectiveness,

¹ Mental Health Parity and Addiction Equity Act of 2008

and whether a drug is generic or brand name – and not on whether its prescribed for medical or behavioral treatment.

- f. **I can't get treatment for behavioral health without prior authorization, but that's not required when I'm seeking medical treatment. OR I was able to start treatment, but I keep having to get authorization to continue.** Plans often apply some authorization standards for different kinds of services. But if they require providers to obtain authorization for behavioral treatment services at earlier stages of treatment or more often (for example, every five outpatient visits), or they apply stricter standards to such services, then they are likely in violation.
- g. **My doctor says I need residential treatment, but my plan won't pay for residential treatment for substance abuse or mental health issues.** In Colorado beginning in 2017, plans overseen by the Division of Insurance must cover residential treatment and intensive outpatient services to the same extent those "intermediate" services are covered under the medical benefit. 3 CCR 702 Reg. 4-2-42, Section 5.1.f.(2). Because Colorado's regulation requires coverage of no less than 100 days of skilled nursing services annually and 2 months of inpatient rehabilitation for medical services, your plan cannot bar those types of services for behavioral treatment.
- h. **I can access medical treatment outside my state, but my plan won't pay for behavioral treatment outside of Colorado.** If a plan limits the geographic location (e.g. plan enrollees must access the benefit from an in-state provider), or the type of facility where behavioral treatments can be accessed, but does not impose those restrictions on medical benefits, a Parity Act violation may exist.

2. What action can I take?

- a. You can ask your provider for help to find out why you have been denied treatment or denied reimbursement, or why your treatment has been reduced or limited. Your provider can submit a letter that explains why the requested treatment is medically necessary.
- b. You are entitled to more information from your carrier, to help you decide whether you want to file an internal appeal.
 - i. You are entitled to a **denial letter** explaining the reason(s) for denial. Always ask for the denial in writing.
 - ii. You are entitled to an **explanation of benefits form** that explains what was requested and denied. To help you consider whether the parity law has been violated, you can compare limitations for behavioral treatment with those for medical benefits.
 - iii. You are entitled to the **medical necessity criteria** your insurer uses to decide whether a type of treatment is medically necessary. You, your provider and any plan participant can request this information. You should request not only the medical necessity criteria for behavioral benefits, but also the criteria for comparable medical benefits, so that the standards can be compared.
 - iv. You will need records and bills from the treatment.
 - v. You may decide to file an **appeal** that claims your carrier violated the parity laws, and you can also file an appeal that claims your carrier did not make the right decision about what was medically necessary.

3. What else can I do if I think the Parity Act has been violated?

The Division of Insurance and Colorado Medicaid can work with you on your specific issue, and they also use consumer complaints to identify problems that need more attention. Those who have insurance

through an employer have other avenues to ask questions or register complaints. State and national contact information follows:

Questions about Plans Overseen by the Colorado Division of Insurance

Colorado Division of Insurance

303-894 7490 (Toll free outside the Denver metro area, 1-800-930-3745)

<https://www.colorado.gov/pacific/dora/ask-question-make-complaint-division-insurance>

Questions about Health First Colorado (Colorado Medicaid) and CHP+

Health Care Policy and Financing

1-800-221-3943 | State Relay: 711 | Fax: 303-866-4411

<https://www.colorado.gov/pacific/hcpf/contact-hcpf>

General Questions and Comments to the Centers for Medicare and Medicaid Services and the Department of Labor

CMS Health Insurance Helpline

877-267-2323 Extension 6-1565

phig@cms.hhs.gov

[\(link sends e-mail\)](#)

[DOL Employee Benefits Security Administration Consumer Assistance](#)

866-444-3272

Questions about Self-Funded State and Local Plans and Church Plans

CMS Health Insurance Helpline

877-267-2323 Extension 6-1565

phig@cms.hhs.gov

[\(link sends e-mail\)](#)