Parity Compliance Problems

1. Higher costs or fewer visits for mental health services than for other kinds of health care.
2. Having to call for permission to get mental health care covered, but not for other types of care.
3. Getting denied mental health services because they were not considered "medically necessary," but the plan does not answer a request for the medical necessity criteria they use.
4. Inability to find any in-network mental health providers that are taking new patients but can for other health care.
5. The plan will not cover residential mental health or substance use treatment or intensive outpatient care, but they do for other health conditions.

(See also https://parityispersonal.org/answers/background/common-compliance-problems and Part IV of the Parity Resource Guide.)

Disclosure of criteria: There is a lack of disclosure by plans of their medical management criteria and information on how they apply medical management techniques to medical/surgical benefits as compared to mental health/substance use disorder (MH/SUD) benefits. To date, few plans provide criteria beyond what is available on their website and no plans have disclosed any details of how they apply non-quantitative treatment limits (NQTLS) to medical versus behavioral treatment services. Plans continue to respond to such disclosure requests with generic statements lacking specificity; asserting the "proprietary" nature of the criteria used; or not responding at all. Plans continue to not respond to disclosure requests for medical/surgical criteria with a referral to their website or no response at all. Plans are also not providing information with respect to how criteria are applied. It is impossible to enforce the parity law without being able to compare the application of NQTLs.

Network Adequacy: Plans generally have fewer providers in their MH/SUD networks than they do in their medical/surgical networks, and consequently, a higher percentage of MH/SUD patients are treated by out-of-network providers as compared to medical/surgical patients. One of the factors that can be attributed to a lack of network adequacy is that physicians and other providers are generally paid lower reimbursement rates than medical/surgical providers, despite MHPAEA requiring parity regarding the same. MH/SUD facilities are also generally reimbursed at lower rates.

Facility-type/Level of care restrictions: Plans generally impose more restrictive limitations and exclusions on facility-types and clinically recognized levels of care for MH/SUD benefits than are imposed on medical/surgical benefits (Notably, non-hospital based residential treatment for SUDs). Plans continue to exclude non-hospital-based substance use disorder facilities from benefit coverage, while covering skilled nursing facilities and rehabilitation facilities under the medical benefit. Plans also continue to exclude clinically recognized levels of care such as partial hospitalization and residential treatment under the behavioral health benefit, while covering comparable levels of skilled nursing care, and inpatient and outpatient rehabilitative care under the medical/surgical benefit.

Lack of Parity in Pre-authorization: Plans generally have more stringent medical management techniques (i.e., pre-authorization and concurrent review requirements, medical necessity reviews, etc.) that are applied to MH/SUD services than to medical/surgical services. Some plans are requiring that their medical directors conduct SUD medical necessity reviews, while care managers continue to conduct reviews on the medical/surgical side.

External review/appeal process: Current guidance significantly limits the external review process to plan determinations involving medical judgment and to rescissions. "Determinations involving medical judgment" do not include many administrative benefit coverage denials that may violate and undermine the parity law, such as the proscribed use of preauthorization for outpatient psychotherapy or blanket exclusions of medically necessary care (that violate the parity statute) for covered conditions or blanket experimental/investigational exclusions of services for covered conditions based on internal Third Party Administrator (TPA) standards that violate plan language. Current guidance also permits self-insured plans to choose the Independent Review Organizations (IROs) with which they contract, inevitably reducing the opportunity for fair and impartial review. No third-party oversight exists of IROs in the self-funded (ERISA) context, who routinely fail to forward TPA-supplied documents for review by claimants prior to adjudicating appeals, fail to directly notice claimants (rather than contracted TPAs) of their determinations, even in urgent cases, and fail to publicly disclose their medical necessity criteria prior to adjudicating external appeals.