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Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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General Comment

Please see attached comments pertaining to the attempt in the Interim Final Rule to control and manage PPO contracting rules with providers and their compensation; the inappropriate definition of "predominant" and the overly broad category of "outpatient" services which actually results in more favorable benefits being required for behavioral and addiction treatment instead of parity.

We believe that these areas are an effort to "rewrite the legislation" rather than interpret it in a reasonable fashion to accomplish the parity per the Act. We ask that serious consideration be given to modifying these provisions or eliminating them entirely.

COMMENTS ON INTERIM FINAL RULE 26 CFR Part 54

The Mental health Parity and Addiction Equity Act (MHPAEA) included the following language. Please see the comments below where we believe that the regulations are attempting to “make laws” and have gone far beyond interpreting and providing reasonable regulations to accomplish the “intent” of the actual law. The regulations when finalized should be reconsidered and modified accordingly.

DEFINITIONS.—In this paragraph:

“(i) FINANCIAL REQUIREMENT.—The term ‘financial requirement’ includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

“(ii) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

“(iii) TREATMENT LIMITATION.—The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Nonquantitative treatment limitations—(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include—

(A) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and (F) Exclusions based on failure to complete a course of treatment.

Comment #1 Definition of Predominant: The regulations are abusive and overreaching in their interpretation of this Act and the new requirements go far beyond that which is granted by the Act, including the definition of “*predominant*” to mean 2/3rd of all the medical benefits paid to establish the maximum copay, deductible, # of visits, out of pocket limit, etc. for ANY behavioral benefit in the same category. **A more “reasonable” definition would be “the most common” or the majority of the benefits in a particular class, for example if more than 50% of the benefits call for a limit of 20 visits, with a provision for extended benefits due to medical necessity, than such requirement should and could similarly be applied to mental health and additive benefits to provide parity.** The 2/3rds requirement is unreasonably restrictive and is not consistent with the language of the Act and will greatly increase costs to plans and greatly complicate testing.

Comment #2 Outpatient Category Too Broad: The creation of the six categories of treatment, especially the category of **outpatient treatment** is overly broad and unreasonable since outpatient medical treatment for medical falls into several major categories of treatment, e.g. office visits, outpatient surgery, chemotherapy treatment, and lab and diagnostic testing. With behavioral health, there is no comparable category for surgery, or chemotherapy, thus parity should essentially be based on the “basic outpatient medical services and therapies. It would be more appropriate to simply compare and limit counseling sessions to comparable outpatient medical services including medical office visits, physical therapy, chiropractic treatment etc. Any lab and diagnostic testing for mental health or addiction disorders should have parity with those same medical categories. The broad category encompassing ALL outpatient medical services result in non-parity and will undoubtedly significantly increase plan costs.

For example: Under our plans we require precert and medical necessity after 20 visits for physical, chiropractic, acupuncture. However, we permit “extended benefits” if it is medically necessary. To provide “parity” with mental health and addiction counseling, the same requirements would be perfectly reasonable and meet with the intent of the law and such should not be precluded because we do not precertify regular medical office visits since typically on the medical side a patient may visit numerous doctors for various issues as opposed to most behavioral treatment utilizes one or two providers for the ongoing treatment.

One type of mental health and addiction treatment generally referred to as “*partial outpatient mental health and addictive treatment programs*” or “*acute partial outpatient therapy*” is unique and there is no comparable medical program unless that was compared to outpatient surgery as both are partial confinement programs vs. inpatient treatment.

It is also perfectly reasonable and fair to utilize the same co pays as for medical provider visits and to allow a higher copay for specialists (PhD’s and MD’s) than for generalists (LSW’s and Master’s level practitioners), similar to the distinction between family/general providers and specialists rather than require some arbitrary tests which take into account all forms of outpatient medical treatment. **Even medical office visits are not comparable to outpatient counseling since office visits usually will vary depending on various diagnosis codes, whereas behavioral counseling is a series of treatment therapies similar to medical therapies such as physical therapy, to treat a particular ailment, injury or diagnosis.** Certainly, there is no correlation between behavioral counseling and medical services like preventive treatment (mammograms, pap smears, prostate exam and colonoscopies), surgery, chemotherapy or radiation; thus those types of medical treatments should not be part of the process to determine the lowest level of copay.

While we do not dispute the importance of providing behavioral and addictive benefits, we do dispute the attempt to make the benefits so favorable that it will result in significant increases in costs to health plans and inordinate efforts to maintain compliance. For example: Plans should not be penalized for having a strong preventive program. Many health plans provide certain medical services at no copay or a lower copay, e.g. preventive, cardiac rehab, preventive tests (prostate, mammograms, colonoscopy, etc.). If a plan’s benefits for such outpatient medical treatment represented 35% of all outpatient benefits paid, this would force the plan to provide unlimited outpatient mental health and addiction treatment at no copay or they would be forced to add copays to preventive treatment. This is counter-productive and an unreasonable application and interpretation of the Act. This would never be an issue if the regulations used the standard definition of “predominant” to mean “majority” or “more than 50%” or **if outpatient services were divided into several categories, such as office visits and all therapy treatment; preventive benefits should be excluded and in its own category; lab and diagnostic testing; and surgery and all other outpatient treatment.**

Comment #3 PPO Contracting Provisions: The MHPAE Interim Final Rule attempts to regulate contractual negotiations of PPO network with providers. This falls far outside the scope of your authority under the law and serves to undermine the rights of insurers and plans to establish provider networks. Typically, the behavioral network is negotiated or leased separately from the medical networks. **Therefore, paragraphs (C) and (D) under Nonquantitative Treatment Limitations should be struck from the interim final rule.** This type of provision would not even be feasible or enforceable when the Behavioral Network is a totally separate network from the medical network(s) and under different ownership/control. In our particular plans, we have a Primary Medical PPO Network that is proprietary and three (3) “leased” medical PPO networks with slightly higher copays that are considered sister or supplementary networks to provide broader access to PPO providers for retirees who live outside the primary coverage area.

Our plans utilize a totally separate Behavioral Network that is not propriety with the Plan or the primary medical PPO. Utilization of this network has enabled us to provide more comprehensive behavioral and addiction services in an environment where providers are matched up based on presenting diagnosis. The result is improved success in terms of the various treatment programs and it has also kept costs reasonable for both members and the plan while providing a high level of care.

MHPAEA is about providing “parity” in terms of receiving behavioral and addictive treatment. There is nothing in the law requiring parity or equal payment to contracted PPO providers. It is only appropriate for a PPO Network or Insurer to negotiate the most favorable rates it can with providers in order to better manage costs for the plan and provide a quality network with providers. While it might sound good to force plans to accept out of network providers, members are often left with extra costs for those providers because there are no controls on what Out of Network providers can charge, and charges often exceed the plan’s UCR rates (for both medical and behavioral services).

This type of language also attempts indirectly to force plans to pay the same for all behavioral services regardless of qualifications. Certainly, payment to a LSW (Licensed Social Worker) should be and always has been less than reimbursement to a PHD or MD, etc. All language of this type is beyond the scope of the actual Act and should be stricken from the final regulations. Using this same logic, plans should be able to differentiate in copays between more cost effective treatment vs. higher cost treatment. Counseling by LSW’s and Masters Psychologists is the most predominant form of a long term counseling program and yet the new regulations would require the copays be the same as for PhD’s and MD’s. This defies any sort of common sense!

The law itself unduly discriminates in favor of HMO plans that permit no out of network benefits in that they are able to control their costs by limiting their behavioral network and services within the restrictive HMO environment. Yet other plans are unable to have an exclusive Behavioral Network. By including the above language it further discriminates against plans that have both in and out of network benefits by providing additional requirements on PPO plans and their networks as compared to HMO Plans with their exclusive network?

The above comments are offered on behalf of the NHAI (National Health Administrators, Inc.) propriety PPO Network. Our plans cover over 6000 individuals.

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