

From: Blanchard, Holly [mailto:Holly.Blanchard@nebraska.gov]
Sent: Wednesday, May 13, 2009 10:28 AM
To: EBSA, E-OHPSCA - EBSA
Subject: Mental Health Parity RFI

To whom it may concern:

The Nebraska Department of Insurance recently received a Request for Information on the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Act of 2008 (MHPAEA). Please find attached our comments to the questions presented.

If you have any questions, or require additional information, please feel free to contact me.

Thank you in advance for your assistance,

Holly Blanchard
Life and Health Administrator
Nebraska Department of Insurance
Holly.Blanchard@nebraska.gov
402-471-4742

MEMO

To: Jolie Matthews, NAIC; Dept. of Treasury, Dept of Labor, Dept of Health and Human Services, Ann Frohman, Director, Nebraska Department of Insurance

From: Holly Blanchard, Life and Health Administrator, Nebraska Department of Insurance

Date: 05/05/09

Re: Mental Health Parity Act RFI

Treasury: Doc 26 CFR Part 54
RIN-1545-B170

Labor: Doc 29 CFR Part 2590
RIN 1210-AB30

Health and Human Services: Doc 45 CFR Parts 144 and 146 [CMS-4140-NC]
RIN 0938-AP65

On 05/04/09 I received a RFI regarding the Mental Health Parity Act. To address questions I have prepared the following response. The information provided is derived from our laws, and from discussions with industry personnel.

Q. What policies, procedures, or practices of group health plans and insurance issuers may be impacted MHPAEA? What direct or indirect costs would result? What direct or indirect benefits would result? Which stakeholders will be impacted by such benefits and costs?

A. Group health plans will be affected in the sense that coverage will be broadened by the implementation of the MHPAEA. A concern that has been addressed is that major group plans will not offer Mental Health, or Substance Abuse Benefits in an effort to avoid applicability of the MHPAEA, thus eliminating benefits that were previously available. It has been estimated that 113 million people across the country will have the right to non-discriminatory mental health coverage, including 82 million individual enrolled in self-funded plans (regulated under ERISA), who cannot be assisted by the current state parity laws. Concerns have been addressed over cost containment issues that could result should these individuals receive treatment that would have previously not been considered for benefits. It can be argued that the benefits would offset the costs in the sense that people who receive the appropriate Mental Health/Substance Abuse treatments will be healthier, and incur fewer claims than they previously would have had their disorder gone untreated. The loss ratio of the insurers could be directly impacted with the use of increased treatments for Mental Health/Substance Abuse. Administrative costs may also rise as there are additional benefits to be considered, additional claims must be paid. These factors could ultimately impact the policyholder through increased premiums.

Q. The statute provides that the term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit. The statute further provides that 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. Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to 1.) medical and surgical benefits and 2.) mental health and substance use disorder benefits? Are these

requirements or limitation applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?

A. Plans currently impose other types of financial requirements or treatment limitations on benefits through aggregate lifetime and annual limits, depending on the verbiage of the contract. Some contracts do not impose lifetime or annual aggregate limits. An additional measure is reasonable and customary deductions (also referred to as usual and customary deductions.) Group plans establish a benefit allowance based on the service, average regional charge, and frequency of occurrences. Financial requirements are currently applied through 1.) Deductibles, copayments, and out-of-pocket expenses. Additional reduction in considerations may be imposed for specific treatments (CPT's). For example, a company (insurer) may pay a surgeon fee at 100%, but a co-surgeon fee at a reduced rate (usually 25%). Provisions will vary by company, but these are common business practices. 2.) Under Neb.Rev.Stat 44-793, legislature determined that if coverage is provided for mental health condition that an insurer cannot establish any rate, term, or conditions that place a greater financial burden on an insured for access to treatment for a serious mental illness. Nebraska laws provide basic coverage of treatment of alcoholism, but do not address other aspects of substance use disorders. With that in mind, companies will provide benefits for coverage for alcohol, or substance use disorders with an aggregate annual limit of visits, or a collective dollar amount limit. Copayments are usually applicable also.

Q. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

A.) A problem may arise in that our statute limits Mental Health benefits to "serious mental illness" including schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression and obsessive compulsive disorder. The MHPAEA does not appear to delineate which mental health disorders fall within its parameters. Additionally Nebraska mandate restricts the types of care provided. In our opinion, it is unclear whether or not the federal act will allow for this since the term "treatment limitation" means "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment", meaning that the MHPAEA states that treatment limitations applicable to Mental Health or Substance Use disorder are no more restrictive than the predominant treatment limitations applied to medical and surgical benefit plans. Clarification also needs to be provided regarding the implementation date of the Act. The Act states it will apply to plans beginning in the first plan coverage year that is one year after the date of enactment (October 3, 2008), which we are translating for most plans will mean the effective date begins January 1, 2010.

Q. What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

A. As previously stated, under Neb.Rev.Stat 44-793, legislature determined that if coverage is provided for mental health condition that an insurer cannot establish any rate, term, or conditions that place a greater financial burden on an insured for access to treatment for a serious mental illness. Nebraska laws provide basic coverage of treatment of alcoholism, but do not address other aspects of substance use disorders. The laws concerning Mental Health benefits are available on our website (www.doi.ne.gov) and can be accessed by the public. All companies must file their group products with the Life and Health Division, where the products are heavily scrutinized to determine that Mental Health

benefits are provided and complaint with our statutes and regulations. This information must be prominently displayed on a policy for the policyholder reference. Once approved, the products become public information and can be viewed by anyone requesting the information. Industry standards are also scrutinized to ensure consumer protection.

Q. What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

A. The Companies must provide a provision in their policies that outlines the grievance procedure for an insured if a claim for Mental Health or Substance Use disorder is denied. The insured is required to have the opportunity to appeal the determination as outlined in Neb.Rev.Stat§44-Article 73. The insured can also request utilization review to determine appropriateness of treatment. All companies must file their group products with the Life and Health Division, where the products are heavily scrutinized to determine that Mental Health benefits are provided and complaint with our statutes and regulations. This information must be prominently displayed on a policy for the policyholder reference. Once approved, the products become public information and can be viewed by anyone requesting the information. Industry standards are also scrutinized to ensure consumer protection.

Q. To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

A. This will again depend on the specific plan. Some plans allow out-of-network coverage for Mental Health disorders at a reduced benefit, while other plans do not allow benefit consideration for out-of-network coverage. All coverage would have to be pre-approved by the Life and Health Division and be compliant with the applicable statutes and regulations.

Q. Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to Federal agencies, state agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?

A. There seems to be much confusion regarding the increased cost exemption. Questions that have been addressed with us include: The companies have to annually justify cost increase of 2% (first year, 1% thereafter) to opt out. How will the initial baseline be determined (how are projected losses to be determined on areas that have never been offered?) If a company continues to opt out annually, how do they track profit/loss ratio's to actuarially justify an increased cost exemption? A model notice would be extremely helpful to facilitate the disclosure process.