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**Sent:** Wednesday, May 13, 2009 12:38 PM  
**To:** EBSA, E-OHPSCA - EBSA  
**Subject:**

### **Concerns Regarding Regulatory Guidance**

- What other financial requirements or treatment limitations do plans currently impose beyond those listed in the law? How are these limitations or requirements imposed on medical or surgical benefits and how are they imposed on mental health or substance use disorder benefits? Are these imposed differently to each class of benefit, and do plans vary levels of coverage within benefit categories?
- What clarifications can and should be made regarding specific terms or provisions to assist with compliance?
- What additional information concerning the criteria for medical-necessity determinations is currently offered by plans and, if it is, to whom and how is this made available? What industry standards or best practices are in place concerning this information and communication of such information?
- Is information currently made available by the plan concerning reasons for denial of reimbursement or payment for services for mental health or substance use disorder benefits, and how and to whom is this made available? What industry standards or best practices are in place concerning this information and communication of such information?
- The Departments are seeking more information regarding the scope of out-of-network coverage for mental health and substance use disorder treatment. Do plans currently offer out-of-network coverage for mental health and substance use disorder benefits and, if so, how is this coverage different from corresponding out-of-network medical/surgical benefits?
- Are there aspects of the increased cost exemption that necessitate further guidance? Would model notices be helpful to assist with disclosure to federal agencies, state agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?

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