

PUBLIC SUBMISSION

As of: May 27, 2009
Received: May 27, 2009
Status: Pending_Post
Tracking No. 809b7486
Comments Due: May 28, 2009
Submission Type: Web

Docket: EBSA-2009-0010

Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: EBSA-2009-0010-0001

Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: EBSA-2009-0010-DRAFT-0116

Comment on FR Doc # E9-9629

Submitter Information

Name: Joshua Brown

Address:

336 Sleepy Hollow Rd
Smithfield, PA, 15478

General Comment

These comments respond to the Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 [RIN 0938-AP65].

In response to Question 1: "Do plans currently impose other types of financial requirements or treatment limitations on benefits?"

Group health plans providing prescription drug benefits often employ formularies or prescription "tiers" to designate drugs that are "preferred" by the benefit plan, and therefore a member who is prescribed a drug in the most preferred tier or a drug on the formulary receives a higher percentage of reimbursement by the plan, a lower required co-payment, or both. There is the potential that such formularies or tiered plans could be manipulated so that prescriptions used to treat mental health or substance abuse conditions are always placed on the less-preferred tiers or rarely make their way onto the coverage formularies. The implementing regulations should ensure that such disparities are clearly prohibited. If mental health or substance abuse patients are guaranteed equal access to health professionals for diagnosis and treatment but are subsequently denied equal access to medications prescribed by those professionals (when compared to

patients being treated by a physician prescribing medications for conditions other than mental health or substance abuse), prohibitively disparate prescriptions costs may make the gains in access to the health professionals all for naught.

In response to Question 1: “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 limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?”

Using The Pennsylvania Employee Benefits Trust Fund (PEBTF) Summary Plan Description of January 2005, a few examples of the current application of financial requirements and treatment limitations follow. This particular Plan relies on a distinct plan of coverage for most of its mental health and substance abuse benefits:

*** (Beginning of Quotations from the SPD)

[EXAMPLE 1:]

Mental Health and Substance Abuse Services

Mental health and substance abuse treatment and services are not covered by your medical plan. Please see the section on the Mental Health and Substance Abuse Program. The first claim for an office visit incurred with a non-mental health and substance abuse professional and coded with a psychiatric diagnosis will be covered by your medical plan.

Medical Detoxification Treatment for Substance Abuse: The medical plan covers detoxification as an inpatient or outpatient, whichever is determined to be medically appropriate by your Claims Payor. For Personal Choice PPO Members: Coverage for detoxification is limited to a Maximum of seven days per admission and four admissions per lifetime. For Basic Option Members: Non-participating substance abuse treatment facilities are not covered.

Special Medical/Behavioral Health Care Benefits: Both your medical and managed behavioral health plans provide outpatient benefits for the diagnosis and medical management of the following conditions: Attention Deficit Disorder (ADD), Attention Deficit/Hyperactive Disorder (ADHD), Anorexia, Bulimia and Tourette’s Syndrome. Under the medical health plan, physicians may diagnose any of these conditions, and prescribe and monitor medications. No counseling benefits are available under the medical health plan.

[EXAMPLE 2 (differential treatment of mental health and substance abuse in Skilled Nursing Facilities):]

Skilled Nursing Facility (SNF)

Benefits are provided for a Skilled Nursing Care Facility (SNF), when Medically Necessary. The Member must require treatment by skilled nursing personnel which can be provided only on an inpatient basis in a SNF. Admission must be for the continued treatment of the same or a related condition for which you had been hospitalized.

No benefits are paid in the following instances:

1. After you have reached the Maximum level of recovery possible for your

particular condition, and you no longer require definitive treatment other than routine supportive care

2. When confinement in a SNF is intended solely to assist you with the activities of daily living or to provide an institutional environment for convenience
3. For treatment of alcoholism, drug addiction or mental illness
4. For intermediate care or custodial care

[EXAMPLE 3 (different coverage for substance abuse treatment than for mental health treatment; the differences in this example relate only to out-of-network providers, so only those portions of the SPD are quoted):]

Mental Health

Outpatient

Non-Network

100% of Usual, Customary and Reasonable (UCR) Charges after \$200 annual Deductible (outpatient/inpatient combined) up to a max of \$35 paid/visit; annual max: 60 visits (network/non-network combined)

Limited to licensed psychiatrists, psychologists, social workers and nurses.

Subject to retrospective review.

Mental Health

Inpatient & Intermediate

Non-Network

70% of Usual, Customary and Reasonable (UCR) Charges after \$200 annual Deductible (outpatient/inpatient combined); annual max: 60 days (network/non-network combined); one physician visit per covered day paid at 70% of UCR after annual \$200 Deductible is met. Subject to retro review.

Substance Abuse

Outpatient

Non-Network

Not Covered

Substance Abuse

Inpatient

Non-Network

Not Covered

Substance Abuse

Ambulatory Detoxification

Non-Network

Not Covered

[EXAMPLE 4 (Extra referrals required when compared to the number of referrals required for non-mental health and substance abuse benefits under the same Plan):]

Network Care

To take advantage of the benefits that are available through the Mental Health and Substance Abuse Program you should follow these steps:

1. Call 1-800-924-0105. You will speak to a trained counselor who will gather basic information to understand your situation and needs.
2. Based on the information you provide, the counselor will refer you to the best-

qualified mental health or substance abuse professional located near your place of work or home. You will be able to get an in-person appointment.

3. After your initial meeting(s), the mental health or substance abuse professional will discuss your needs and treatment goals with a UBH counselor and an individual Treatment Plan will be developed. If, after your initial appointment, you decide that you would like to see a different mental health or substance abuse professional, you must contact your UBH counselor for a new referral.

*** (End of Quotations from the SPD)

In addition to the examples above, virtually every benefit provided under the Mental Health and Substance Abuse Program through the PEBTF-selected program administrator (United Behavioral Health) requires a special notification to UBH, pre-certification from UBH before receiving services, or pre-authorization from UBH before receiving services; such extensive notification and pre-clearance requirements do not apply to the medical and surgical benefits program.

In response to Question 2: "What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?"

Certain group health plans contract with one or more outside professional Claims Payors to administer benefits for different types of coverage. For example, a group health plan might contract with a distinct Claims Payor for benefits related to mental health and substance abuse benefits, another distinct Payor for prescription drugs, a third distinct Payor for vision care, a fourth distinct Payor for dental care, etc. Because in such cases, different types of benefits are administered by separate entities, what may appear to be a generally applicable benefit provision, neutrally-administered by a Claim Payor for mental health and substance abuse benefits, could in fact be a more burdensome or restrictive requirement than the provisions applied by the distinct Claims Payor for medical and surgical benefits under the same group plan. Without a requirement that group health plans coordinate determination criteria and rule applicability among their outside Claims Payors, an outside Claims Payor for mental health and substance abuse benefits may effectively subvert the requirements for mental health parity by crafting administrative rules that differ from those applied by the medical and surgical benefits Payor.

As an example of this possibility disparity, please see the The Pennsylvania Employee Benefits Trust Fund (PEBTF) Summary Plan Description of January 2005. The 2005 SPD states that "The Board of Trustees [of PEBTF] has the sole and exclusive authority and discretion to interpret and construe the Plan Document, amend the Plan Document, determine eligibility and resolve and determine all disputes which may arise concerning the PEBTF, its operation and implementation. The Board of Trustees may from time to time delegate some of its authority and duties to others, including PEBTF staff and the Claims Payor for each of the Plan Options." Because the PEBTF maintains sole and exclusive authority over the operation and implementation of the Plan, and also possesses the power to delegate, as it sees fit, those same functions to Claims Payors, it may delegate certain interpretive functions to a mental health and substance abuse benefits Payor that it does not delegate to a medical and surgical claims Payor, or vice versa. This delegation would further the MHPAEA's purposes if the

Board of Trustees maintained continuous oversight to ensure that the functions it delegated to Claims Payors did not lead to disparate and unequal implementation of the Plan Options. But in the absence of such oversight, delegated interpretive and implementing decision-making by these Claims Payors may result in less favorable treatment of claims for mental health and substance abuse benefits. The PEBTF's 2005 SPD specifically precludes such oversight: "The Board of Trustees will generally not overturn on appeal a decision made by the Claims Payor which is made within its authority under the terms of the Plan Document."

A more particularized example of this same problem centers on the PEBTF's payments of either a "Usual, Customary and Reasonable" (or "UCR") charge or a percentage of the "Plan Allowance."

The SPD Glossary defines "Plan Allowance" as follows:

*** (Beginning of Quotations from the SPD)

Plan Allowance: Certain Claims Payors determines the maximum covered expense for a Covered Service by means of the Plan Allowance, rather than by determining the UCR Charge. The Plan Allowance means the fee determined and payable by the Claims Payor for Covered Services as follows:

- a. For Preferred Providers, the Plan Allowance is the lesser of the Provider's billed amount or the amount reflected in the Fee Schedule determined by the Claims Payor. The Fee Schedule is the document(s) that outlines predetermined fee maximums that Participating and Non-Participating Providers will be paid by the Claims Payor, as amended from time to time.
- b. For Participating Facility Providers, the Plan Allowance is the negotiated amount agreed to by the Provider and the Claims Payor. For Non-Participating Facility Providers, the Plan Allowance is the amount charged by the Facility Provider to all its patients, but not in excess of the Fee Schedule or other maximum payment amount, if any, established by the Claims Payor with respect to Non-Participating Facility Providers.

*** (End of Quotations from the SPD)

The SPD Glossary defines "Usual, Customary and Reasonable Charge" as follows:

*** (Beginning of Quotations from the SPD)

The Maximum covered expense for a Covered Service in the service area. Expenses in excess of the UCR Charge are the sole responsibility of the Member. The UCR Charge is determined by the Claims Payor under the particular Plan option you have selected (PPO, HMO, Basic, Mental Health and Substance Abuse Program or Supplemental Benefits), in accordance with the following factors:

- The usual fee which an individual Provider most frequently charges to the majority of patients for the procedure performed
- The customary fee determined by the Claims Payor based on charges made by Providers of similar training and experience in a given geographic area for the procedure performed
- The reasonable fee (which may differ from the usual or customary charge) determined by the Claims Payor by considering unusual clinical circumstances; the degree of professional involvement or the actual cost of equipment and facilities involved in providing the service

The determination of the UCR Charge made by the Claims Payor will be accepted

by the PEBTF for purposes of determining the Maximum amount or expense eligible for coverage under the Plan. Certain Claims Payors use the “Plan Allowance” in place of the UCR Allowance. Any reference to “UCR” or the “UCR Allowance” shall be deemed to refer to the “Plan Allowance” for those Plan Options which are administered by a Claims Payor that use the Plan Allowance.

NOTE: Certain Claims Payors use the “Plan Allowance” instead of the UCR Charge for determining the maximum covered expense. Any reference hereunder to the “UCR” or the “UCR Charge” shall be deemed to refer to the Plan Allowance for those Plan Options administered by a Claims Payor that uses the Plan Allowance.

*** (End of Quotations from the SPD)

Because the PEBTF allows Claims Payors to decide whether to pay the UCR Charge or the Plan Allowance, if the mental health Payor selects one method and the medical and mental health Payor selects another, disparate benefit payments could result. Further, if the plan were so inclined, it could even select Claims Payors precisely because they use either the UCR Charge or the Plan Allowance charge to determine payment amounts, where one method would be systemically cheaper to the Plan than the other method.

Finally, the Plan accepts the determinations of individual Claims Payors as to which procedures and therapies are experimental or investigative, and therefore not eligible for benefit payments. If a Claims Payor for medical and surgical benefits takes an expansive view of what procedures and therapies are covered (i.e., it is less likely than other Claims Payors to find that a treatment is not covered because it is experimental or investigative) and a Claims Payor for mental health and substance abuse benefits take an expansive view of what procedures and therapies are experimental or investigative (i.e., it is more likely than other Claims Payors to find that a treatment is not covered because it is experimental or investigative), then benefit disparities would result in the distribution of benefits.

These and other potential disparity problems require further clarification about the requirements for group health plans that include distinct Claims Payors for different benefits.

In response to Question 5: “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?”

Please see the response to Question 1, labeled as Example 3, above, in which out of network benefits are not paid for substance abuse treatments but are paid for mental health treatments. Medical and surgical benefits include out-of-network coverage, except for the HMO Option of the Plan. The amount of coverage for out-of-network medical and surgical benefits is, on the whole, the same for out-of-network inpatient mental health benefits. According to the SPD, both benefit types are covered at 70% of the Usual, Customary and Reasonable (UCR) Charges (or Plan Allowance). However, one severe restriction on out-of-network outpatient mental health services is that the per-visit payment is limited to \$35.

There is no such maximum on medical services out-of-network, and obviously, \$35 would rarely (if ever) even close to 70% of the cost of an outpatient visit for mental health treatment.

For reference purposes, The Pennsylvania Employee Benefits Trust Fund (PEBTF) Summary Plan Description of January 2005 has been included as an attachment with this comment submission.