

**From:** Steve.Pankey [mailto:Steve.Pankey@healthalliance.org]  
**Sent:** Friday, May 29, 2009 1:27 PM  
**To:** EBSA, E-OHPSCA - EBSA  
**Subject:** Federal Mental Health Parity rulemaking concerns

To whom it may concern:

Thank you for providing us with this opportunity. We have the following concerns with HR 1424 that we believe could be clarified under rulemaking:

1. The provision regarding predominate financial arrangements could be clarified. For example, plans that mainly express co-pay/coinsurance with one or two benefits that contain day/visit limits.
2. If a plan predominantly uses co-pays for medical surgical benefit, can a plan have a coinsurance for mental health and substance abuse disorders?
3. We have concerns with state preemption. Some states mandate coverage for certain mental health care diagnoses at a day/visit limit and some states mandate that plans cover autism at a specified annual maximum benefit, typically \$36,000. What would be allowable for states to mandate under the new parity law?
4. What constitutes a separate but equal deductible? For example, a plan imposes a \$5,000 overall deductible for medical surgical benefits, would it be allowable to have a separate but equal \$5,000 deductible for mental health and substance abuse disorders, but that does not apply to the overall plan deductible?
5. For determining medical necessity, is it appropriate to require the treating physician to provide the insurer with a treatment plan that contains an expected termination date, in order to provide some cost containment measures on coverage?
6. How does parity apply between residential treatment, intensive outpatient or partial hospitalization programs?
7. Illinois law (215 ILCS 5/370c(a)) requires HMO's that cover non-serious mental health care to allow a covered person to go out of network for mental health care services, without the approval of their primary care physician and without preauthorization. There is no coverage for substance abuse out of network. Would this parity requirement require coverage of substance abuse disorder the same as mental health care?
8. Under the same Illinois law, an HMO plan may impose a 50% coinsurance for mental health services received out of network. If the HMO charges an in-network \$20 co-payment for mental health services, would the HMO be required to cover the out of network mental health services at the in-network co-pay level or would it be allowable to continue to charge the out of network 50% coinsurance? For questions, 7&8, with the exception of an emergency, there are no other services covered out of network on the HMO.
9. Under current law, a non-federal public employee self-funded plan can opt out of parity. Will these plans be able to continue to opt out of parity under the new law?
10. For the cost exemption, when does the exemption actually begin? Does it begin on the date that the third plan year begins, following two full years of experience?

If you have questions, please let me know. Again, thank you for this opportunity for us to share our concerns for rulemaking of this new law.

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