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

Comment On: IRS-2009-0008-0120

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

Document: IRS-2009-0008-0130

Comment on FR Doc # 2010-02167

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General Comment

See attached file.

Attachments

IRS-2009-0008-0130.1: Comment on FR Doc # 2010-02167

COMMENTS ON 26 CFR Part 54 [TD 9479] RUB 1545-Bjh05

For purposes of the Final Rule, however, we believe there is a need for further guidance and clarification with respect to the following:

1. **Exemptions for Non Federal Governmental Units:** Self funded plans and plans of non federal governmental units, such as negotiated plans with school districts, are supposed to be exempt from this law under both ERISA and the PHS regulations. Yet these regulations REQUIRE that if a plan provides for mental health and addictive benefits, they must comply with these regulations. This seems to be overreaching on the part of the departments and it is our believe that such exempt plans should be permitted to provide for mental health and addiction benefits under their own rules and should not be subject to the rules set out in these regulations. An all of nothing rule is not beneficial if plans resort to not covering mental health and addiction benefits at all. Exempted plans should be able to design their behavioral and addiction programs as they see fit.
2. **Non Compliance Penalties:** Penalties for non-compliance are not addressed. These should be spelled out in the regulations.
3. **Suicide Clauses/Intentional Injury Clauses:** Permissibility of a suicide clause where a plan limits or excludes benefits in the case of an attempted suicide. Since suicide is not a disease per se, would such a clause be permissible?
4. **DWI Injuries:** What about excluding benefits (medical or behavioral) where injuries were incurred as a result of the patient being issued a DWI citation, which is an illegal act? Would such exclusions be permitted?
5. **Penalties for Failure to Complete Treatment:** One of the penalties mentioned in the Interim Final Rule dealt with penalties for *“failure to complete a treatment program.”*
 - a. Would it be permissible for a plan to not cover any benefits at all for a treatment program where the member refuses to complete the program or checks themselves out against medical advice?
 - b. Would it also be permissible to reduce the benefits in this situation by 50% as a penalty for refusing to complete the program and not credit the member coinsurance toward s the out of pocket
 - c. Would it be permissible to penalize the member with an additional hospital copay or deductible for any readmission within the next 12 months following a treatment program which the patient refused to complete or checked themselves out of the program against medical advice.

We believe any of these penalties should be permitted if penalties apply to either medical or behavioral treatment since medical treatment could actually include situations where a member refuses to stay in the hospital or complete medical treatment, including medical treatment for detoxification. It is absolutely essential to have some control over abuse by members who go in and out of treatment programs with some frequency 3 and 4 times during an 18 month period. There needs to be some member or patient responsibility and accountability.

6. **Methadone or Other Maintenance Treatment:** The Final Rule should clarify that Methadone Treatment or Maintenance can be excluded by the plan. The plan should not be required to supply maintenance drugs for a drug habit. There is a great deal of abuse in such treatment programs today which prolong getting an individual off their addicted drug of choice.
7. **Partial hospitalization/confinement Programs:** These programs could fall under inpatient or outpatient treatment as it is a combination of both. Typically, a partial hospitalization program is appropriate in situations where inpatient confinement is not medically necessary. When inpatient treatment is not medically necessary or where additional treatment is needed following an inpatient program, there is a unique category of treatment, e.g. **partial outpatient or acute outpatient program** where the patient is inpatient for 4 to 10 hours during the day and then is able to go home at night or to a group home. This level of treatment does not have a comparable medical program unless outpatient surgery where the patient is in the hospital less than 23 hours would be considered comparable.

Previously, such a program might be credited on a 3 to 1 basis in lieu of inpatient treatment. Accordingly, in terms of copays, which rules would apply? The same copay as for counseling or a pro-rata copay based on the inpatient copay? Where should such a program fall?

8. **Segregated Deductibles and Out of Pocket Limits:** Since the law did not specify that deductibles and out of pocket amounts must be aggregated for both medical and addictive and behavioral treatment, we believe that the Departments have overstepped their regulatory authority by prohibiting separate deductible and out of pocket limits for behavioral and addictive treatment and request that separate limits be permitted.
9. **PPO Provider Negotiations:** Insurance companies and PPO networks should be free to negotiate provider contracts as a matter of contract law and those negotiations should be subject to no limits or constraints under these regulations. With the regulations as written you are in effect mandating increased payment to certain providers which in turn will increase the cost of providing these benefits. This is hardly in keeping with the projection of nominal increases in costs, e.g. .4% of less.

There should be no restriction on provider negotiations, e.g. that they be identical to medical providers. We take no issue with requiring the same UCR fees for behavioral as for medical; but all language pertaining to network negotiations should be eliminated from the regulations.

The regulations should absolutely permit PPO Networks and Insurers to negotiate rates with providers and to negotiate different rates depending on the type of provider. The regulations go beyond the intent of the law by requiring that the fees to be the same as for medical providers without allowing for a distinction in rates and benefits for social workers versus PhD's and MD's. **This will accomplish one thing only--increase costs for plans.** Further, if there is a distinction between primary care physicians and specialists or between different types of PPO providers, a similar distinction should be permitted for mental health and addiction providers.

For example, under our plans we have lower copay for Primary PPO providers and a slightly higher copay for PPO providers in "sister" leased networks in order to provide broader coverage for our members. Plans should be permitted to have a lower copay for the majority of the counselors, which are social workers, or master's level counselors,

versus a higher copay for Phd's and MD's which plans should be able to treat as specialists.

As a Third Party Administrator we would take issue with the Department's estimate that mental health and addiction expenses would only increase .4% as a result of this new law. A more reasonable estimate would likely put increase in mental health/addiction costs at 50 to 100% over prior levels, which given the high cost of health care today only adds to the burden on employers and employees.

The review time to determine if a plan is in compliance of ½ hour is ludicrous. Each plan must be evaluated on its merits and if a plan has various tiers of member copays or coinsurance, some actuarial calculations and analysis may be in order. This is not something that can be undertaken without spending considerable time on the overall process. Even the 5 minutes estimated to respond to a request for disclosure of the medical necessity rules is grossly understated. By the time a phone call is taken or a letter is reviewed, it would take 10-15 minutes to provide the information requested via email, fax, letter, etc. and the time may well vary from a minimum of 10 to 15 minutes to as much as 30-45 minutes to answer an inquiry from a member or provider. Given the extreme measures required for compliance per these regulations, costs for behavioral health are bound to increase significantly since there are very few options for a plan to control costs, which is unfortunate.