PUBLIC SUBMISSION

As of: May 03, 2010
Received: May 03, 2010
Status: DoNotPost
Tracking No. 80ae59c6
Comments Due: May 03, 2010
Submission Type: Web

Docket: EBSA-2009-0010
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: EBSA-2009-0010-0409
Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: EBSA-2009-0010-DRAFT-0691
Comment on FR Doc # 2010-2167

Submitter Information

Name: Sheryl Bonner
Address:
P.O. Box 9201
Austin, TX, 78759
Email: sheryl@boonchapman.com
Phone: 512-454-2681
Organization: Boon-Chapman Benefit Administrators

General Comment

See attached file(s)

Attachments

EBSA-2009-0010-DRAFT-0691.1: Comment on FR Doc # 2010-2167

Boon-Chapman is a third party administrator headquartered in Austin, Texas. We administer self-funded plans sponsored by employers. We appreciate the opportunity to submit this comment.

We are concerned that the limited benefit classifications provided in Interim Final Regulations will create adverse and unintended consequences. The problem results from the outpatient/ in-network and outpatient/ out of network classifications being too broad. These categories include, among other things, outpatient hospital services, physician office visit services (primary care and specialty) and wellness services.

Most plans provide for different benefit structures for some, if not all, of these categories. For example, many plans cover outpatient physician services at 100% after the participant pays an office visit copay of $20-$40. Further, a lot of plans impose a higher copay for specialty services to incent primary case usage. Also wellness is often covered at 100% with an annual limit of $500-$1000. Whereas other outpatient services (including hospital services) are subject to a deductible and are then paid at 80-90% of charges up to an out-of-pocket maximum of $2000-$5,000.

I have outlined a sample plan design below to help illustrate the problem. This is a common plan design for out-patient services. Assume for simplicity's sake assume the plan only covers in-network outpatient services for employees.

Coverage Categories

1) Physician office visits-$20 copay then plan pays 100%.

2) Wellness services-100% coverage up to a $500 annual maximum.

3) All other outpatient services- $500 deductible then 90% coverage up to a $2,000 out-of-pocket maximum.

The regulations prevent a plan from imposing a financial requirement that is more restrictive than the predominate financial requirement that applies to substantially all medical/surgical benefits in a classification. Each of the three coverage categories above imposes a separate financial requirement. It is unlikely that any one of them will meet the two-thirds/substantially all requirement. Therefore, all in-network outpatient services for mental health must be paid 100%, without a copay or a deductible.

This isn't the intention of the law and would strongly encourage plan sponsor to eliminate mental health coverage and should be corrected by adding additional categories for out-patient hospital services, wellness services, specialty physician office visits and primary care physician office visits.

We are also concerned with prescription drug benefits. Under the interim regulations if a plan provides mental health coverage in any benefit classification, it must provide the coverage in all categories in which the plan covers medical/surgical benefits. This seems only fair, but with prescription drugs it is problematic.

Most plans that don't cover mental health benefits generally don't exclude prescription drugs prescribed for mental health conditions. Our experience is that they don't impose this limitation on prescription drugs because the cost and participant inconvenience is too great. This is because prescription drug claims (unlike medical claims) are submitted without a diagnosis and many drugs can be used for the treatment of mental health and medical/surgical conditions. To enforce the mental health prescription drug exclusion, the pharmacy would have deny any claim that could have been prescribed for a mental health condition. This will often occur while the participant is waiting at the pharmacy. If the prescription was for a medical/surgical diagnosis the participant would have ask her physician to submit a letter of medical necessity confirming that fact. Then the letter would have to be reviewed by the Pharmacy Benefit Management Company (PBM). Next an override would need to be placed in the PBM's computer system, allowing the participant to return to the pharmacy and obtain her prescription. This would create unnecessary expense and member dissatisfaction. We recommend that mental/nervous prescriptions be allowed to be covered, regardless of whether a plan covers mental/nervous benefits in the other classifications.