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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

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General Comment

The issues are: 1) Benefits for mental health and substance use must be provided at parity with the medical/surgical benefits that includes length of stay and access for each classification : Inpatient, in-network; Inpatient, out-of-network; Outpatient, in-network; Outpatient, out-of-network; Emergency care; Prescription drugs. 2) Other concerns are that the IFR does not cover Medicaid managed care plans despite that the parity law applies to Medicaid. While the DOH is expected to release information on how parity applies to Medicaid managed care soon, the concern is that it should be applied equally so as to not have two different standards. 3) An excellent development was that the IFR creates a new category called “non-quantitative treatment limitations,” which prohibits limits that are different than medical benefits. The concern is that the IRF emphasize the need for insurers to not employ the following for restricting care: a) medical management, (insurers stating that clients don’t qualify for longer terms or levels of care rather than relying on assessment standards); b) requiring prior authorization rather than relying on assessments; c) prescription formulary designs; d) “fail-first” or step therapies (insurers demanding clients fail at OP first before accessing higher levels of care.) 4) The federal agencies weren’t appropriated any additional money by Congress to enforce the parity law. The concern is that any law is only as good as its enforcement provisions. 5) Create an organized process to track how insurers are responding to parity and how to remedy any problems. 6) We suggest an information process to inform community that there is significant evidence that parity and treatment more than offsets other health care costs. The evidence is so convincing that many analysts believe that insurers and business groups oppose parity because of a cultural mindset rather than a cost study or medical necessity approach. 7) We want to advocate for eliminating the clause that plans having no treatment options or groups under 50 do not have to comply with parity rules. The hope is that the health care reform bill will remove this option.

Attachments

EBSA-2009-0010-DRAFT-0531.1: Comment on FR Doc # 2010-2167

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

The issues are:

1. Benefits for mental health and substance use must be provided at parity with the medical/surgical benefits that includes length of stay and access for <u>each classification</u> :
   - Inpatient, in-network.
   - Inpatient, out-of-network.
   - Outpatient, in-network.
   - Outpatient, out-of-network.
   - Emergency care.
   - Prescription drugs.
2. Other concerns are that the IFR does not cover Medicaid managed care plans despite that the parity law applies to Medicaid. While the DOH is expected to release information on how parity applies to Medicaid managed care soon, the concern is that it should be applied equally so as to not have two different standards.
3. An excellent development was that the IFR creates a new category called "non-quantitative treatment limitations," which prohibits limits that are different than medical benefits. The concern is that providers emphasize the need for insurers to not employ the following for restricting care:
   - medical management, (insurers stating that clients don't qualify for longer terms or levels of care rather than relying on assessment standards)
   - requiring prior authorization rather than relying on assessments
   - prescription formulary designs,
   - "fail-first" or step therapies (insurers demanding clients fail at OP first before accessing higher levels of care.)
4. The federal agencies weren't appropriated any additional money by Congress to enforce the parity law. The concern is that any law is only as good as its enforcement provisions.
5. Create an organized process to track how insurers are responding to parity and how to remedy any problems.
6. We want to inform legislators and the public that there is significant evidence that parity and treatment more than offsets other health care costs. The evidence is so convincing that many analysts believe that insurers and business groups oppose parity because of a cultural mindset rather than a cost study or medical necessity approach.
7. We want to advocate for eliminating the clause that plans having no treatment options or groups under 50 do not have to comply with parity rules. The hope is that the health care reform bill will remove this option.