coalition for the homeless

May 28, 2009

by email to E-OHPSCA.EBSA@dol.gov

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653,
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Dear Sir or Madam:

I write in response to the joint Request for Information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

I am the Deputy Executive Director for Policy with Coalition for the Homeless, a non-profit direct service and advocacy organization based in Manhattan and a member of the Steering Committee of the Timothy's Law Campaign which secured passage of our mandated minimum mental health insurance and parity law, entitled Timothy's Law, in 2006. We also played an instrumental role in the negotiations on the new federal law, and in particular the modifications intended to leave Timothy's Law and other very strong state laws intact or strengthened by, but in no way weakened, by the new federal law.

We believe the language of the act is true to this purpose, having consulted at length with both the NY Delegation and the House and Senate sponsors, as well as our Governor's Office, the NYS Office of Mental Health, and the NYS Insurance Department.

However, we met with the industry and our Insurance Department following the enactment to review the implications of the Act as it will apply in New York and discovered that there may be some further issues for interpretation that should be called to your attention so that the intent of the Act is preserved in the rulemaking process.

Let me start by making a very clear note that it is our understanding that the interaction between federal and state law in the case of New York, will be that our mandated minimum benefits for mental health and chemical dependency (at least 20 outpatient visits and 30 inpatient days for mental health, and a separate 60 outpatient visits for chemical dependency) would be uncapped for the large fully insured group plans to the degree that they are treated as maxima by the plans, and because these plans are required to provide coverage of diagnoses that is no more restrictive than our state employee benefit plan (which covers all in the DSM IVr except a handful of the "v-codes" for which no practice guidelines are published), the enhanced unlimited coverage unde Timothy’s Law for selected "biologically-based" mental illnesses and selected children's diagnoses will be rendered obsolete for these groups with one exception.

The exception would be if the plan were to exercise its option to exempt itself from the operation of the federal law, in which case it would again be subject to the two-part requirement of state law. (We think that would be an extremely rare exception because the bulk of the costs of complying with mental health

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mandatory coverage and parity requirements have already taken place under state law, and state-regulated plans will be hard-pressed to show the requisite premium increases in order to qualify for the exemption based solely on the operation of the federal law.)

Further, it is our understanding that state regulated health plans in New York that are subject to the federal law will be required to provide coverage for both mental health care and chemical dependency treatment, on both an inpatient and an outpatient basis.

We understand that some health plans believe in the absence of a mandated inpatient benefit for chemical dependency treatment in state law, that they will remain free to refuse this coverage even after the new federal law takes effect.

We believe they are wrong for three reasons. First, the new federal law is clear that if a plan provides mental health ***or*** substance abuse benefits, it must comply with the new parity requirements. This means if a plan only provides chemical dependency and not mental health coverage, it must provide both when the federal rules take effect, and if it provides inpatient coverage for either mental health or substance use disorders, it must also provide outpatient coverage for both types of disorders.

Second, some benefits in some plans (like our Family Health Plus program for low income families) are blended benefits, so that an inpatient or outpatient benefit is provided for x number of days of inpatient coverage for both chemical dependency and mental health treatment, and y number of days of outpatient treatment for either chemical dependency or mental health needs, or both.

Third, some treatments are not distinctly inpatient or outpatient services. The most obvious of these is "partial hospital" which takes place as a hospital based day service that, for example in NYS, is counted as two partial hospital days exchanged for one hospital inpatient day. We would urge a federal rule on this exchange as well, and that it be three for one, rather than two for one, since partial hospital days are typically less than eight hours.

Finally, it is our understanding that the new federal law has a very useful new rule that may require New York to modify what constitutes parity in cost sharing. Over our objections, New York has allowed health plans that have tiered co-pays to charge mental health visit co-pays at the specialty rather than at the primary care rate. The problem we have with this practice is that many mental health services are really primary care types of services, and because of their frequency, specialty co-payments can become prohibitively costly for consumers. Such a practice is not commonly used with other "specialists" when they perform primary care functions. For example, an endocrinologist can be the primary care provider for a patient with diabetes who will be charged a primary care co-payment for even frequent visits.

Turning to the solicited comments, I hope the above remarks are responsive to some of the questions about practices of group health plans that may be impacted. Regarding the questions relating to regulatory guidance, i will not repeat the above, although all of these matters should be considered in the development of the regulations.

With respect to the remaining questions, I wish to discuss a few points:

1. The New York State Department of Health maintains that Medicaid managed care programs such as child health plus are not "group" policies and therefore not covered by the federal parity law. I and others disagree. We know that the CBO estimated costs of compliance for these programs in association with the federal enactment, and the prior federal parity requirements applied to them as well. Further, I

note that Community Advocates Public Policy Institute has provided extensive comment (May 19 2009 addressed to CMS) on this matter, and we join in their call for regulatory direction to states on this so that the regulators, plans, providers and consumers all are aware that parity does indeed apply.

As you may be aware, for Child Health Plus this is a somewhat moot point because parity is included in the separate and more recent S-chip reauthorization. We have confirmation from our Governor's Office that NYS is complying, but were advised that implementation could not be effected immediately. The effective date was April 1 and some time is needed to adjust rates and for the plans to ramp up their networks to meet the network adequacy requirements. Further, it is my understanding that even if a Medicaid managed care limit is applied to a mental health service, the services above the limit are subsequently covered as fee-for-service or stop-loss payment, so recipients may not be facing serious harm due to the lack of parity in our Medicaid program. Nevertheless, it is necessary for the ground rules to be made clear to all concerned.

2. Residential rehabilitation (or crisis residence) services are a problem area since for mental health these tend not to take place in a "rehab," but in a residence (for which there may or may not be a comparable service). The NYS Insurance Department allows plans to deny coverage for mental health residential services, even though these are licensed in NY and provide rehabilitation services. For chemical dependency, rehabilitation may or may not be covered, depending on plan benefits and auspice of the rehabilitation service. It appears hospital-based rehabilitation is more well accommodated by health plans than residential rehabilitation services, notwithstanding that residential rehabilitation is more cost-effective. By contrast, with physical and brain injury, rehabilitation is a known quantity and covered - rehab - period, although it is typically a hospital-based service. Assuring that residential rehabilitation is covered should be an important focus of the rule making.

3. Medication management visits: We agreed with the plans and the NYS Insurance Department that such visits (typically a 15 minute review of blood work, side effects, interactions, efficacy, and any needed adjustments) are not to be counted against mental health benefits minima, but this has posed a problem in some complaints in the wake of Timothy's Law where plans are counting these visits as mental health visits. Federal direction to prohibit this would be of help.

4. The most serious problems with medical management are that our state regulators cannot reverse a bad decision upheld on external appeal - it has to be litigated. This is true for both mental health and physical health matters, but it appears to me that there should be some way to overcome bad clinical analysis that falls short of litigation, especially in complex areas like mental health and addiction. It may be that the new federal rules about medical necessity disclosure can help with such problems, or that the rules could empower regulators to accept clinical documentation sufficiently robust to permit them to overturn such denials when there is clear error in an external appeal decision.

5. There is a kind of gaping hole with respect to coverage of services for those with autism spectrum disorders. Those with milder conditions like Aspergers disorder as well as those more severe instances of autism face the same problem - the schools and the insurance plans both deny services, endlessly passing the buck back and forth. Each says the other is responsible for the various tests and services, even when the service is called for by licensed evaluators; even when all agree the service is needed, but disagree about whether it is for academic or emotional or social or other needs; and even when the child has no IEP, or a declassified IEP. Even then, insurance plans deny coverage and make parents pay out-of-pocket on the grounds that the services are needed for academic, not medical needs.

There needs to be a "default" payor" for testing and treatment for this unique set of conditions where a wide array of educational, occupational, physical, and psychiatric assessments, tests and treatments are needed. It is clear that at times, the default payor or safety net should be insurance coverage, while in other instances it should be the educational system - it is very complex to sort out, but quite necessary. Further, these disorders are considered "of childhood" notwithstanding the fact that these children become adults without adequate support and services.

Recent coverage in the New York Times, including an article about expensive educational services, and an op-ed about the needs of adults with autism help to illustrate the complexity of the problem and the inadequacy of the current structures. Unfortunately, the solutions to this area of controversy appear to require the navigation of some tricky boundaries between the educational and health care systems. As many states are now examining legislation to mandate better coverage or educational services for people with autism, it may be suitable for the regulations to weigh in on this subject as well.

6. Not unrelated to the problem of covering services needed by children and adults with autism is the problem of obtaining coverage for so-called experimental services. I would note that this is a problem across healthcare, but more so in the area of autism and chemical dependency than in other mental health areas, at least from what I observe as I review Timothy's Law complaints. Perhaps federal guidance could help with this problem.

7. A serious problem we witness, for which we hope there may be a federal regulatory remedy, it the use of a retrospective medical necessity determination to revoke approval for coverage of a prior authorized service. Federal regulations should rein in this problem.

In closing, I welcome any opportunity to help further inform the rule making process should there be a need to explore these matters further.

Thank you for your interest and consideration.

Yours,

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