DEPARTMENT OF
Managed
Health Care

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

April 29, 2010

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–4140–IFC
P.O. Box 8016
Baltimore, MD 21244–1850

RE: FINAL INTERIM RULES UNDER THE MHPAEA (FILE CODE CMS–4140–IFC)

Dear Ms. Frizzera:

The California Department of Managed Health Care (DMHC) appreciates the opportunity to comment on the Final Interim Rules (the Rules) under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The DMHC is the California agency that licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975. There are 108 health plans providing managed health care services to 21 million Californians and operating under this state licensing law.

The DMHC has identified several areas for which additional clarification would be helpful so that interested parties (health plans, providers, consumers) would better understand their rights and obligations under the federal laws.

I. Clarification of Classification of Benefits

The Rules require that parity be determined and applied on a classification-by-classification basis. In other words, parity is determined by comparing inpatient/in-network behavioral health benefits to inpatient/in-network medical/surgical benefits; and outpatient/in-network to outpatient/in-network, and so forth for the six benefit classifications specified under the Rules. However, certain health care services are not

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clearly classified as "inpatient" or "outpatient" benefits, because they provide an intermediate level of care. For example, health plans can provide "rehabilitation benefits" for patients who no longer qualify for inpatient hospital benefits, but who still require some custodial care or supervision while they receive treatment for their underlying condition (e.g., stroke). Similarly, health plans can provide benefits for residential treatment. Residential treatment can be provided to patients who require continued treatment for certain mental health conditions or substance use disorders, but who do not require psychiatric inpatient hospitalization. Residential treatment facilities are typically not licensed as hospitals, but may provide services that complement or exceed the scope of typical outpatient care.

Furthermore, health plans can provide benefits for behavioral health services that have no analogous services on the medical/surgical side, thereby making parity difficult to ascertain under the Rules. For example, under California law, health plans must provide partial hospitalization benefits for certain mental health conditions. Partial hospitalization, also known as "day hospitalization," is essentially a hybrid of inpatient and outpatient care in which the patient participates in structured therapy and treatment for several hours in a hospital or clinic, and then returns to his or her own residence.

In issuing the Rules, the Department of Health and Human Services, the Department of Labor and the Department of the Treasury (the Departments) did not specifically define the benefits that constitute inpatient and outpatient services for the purposes of classifying benefits.

Accordingly, further consideration should be given to providing clarity in these areas to help avoid misunderstandings by various affected parties about how certain services should be classified for the purposes of applying the Rules.

II. Clarification of Partial Day Equivalencies

Related to the issue of intermediate-level benefits or benefits unique to the treatment of behavioral health is the use of partial-day equivalencies. For example, a health plan may treat one day of partial hospitalization as equivalent to one-half of a day of inpatient hospitalization. It is not clear whether this practice is permitted under the Rules or how parity in financial requirements or quantitative treatment limitations should be applied when a health plan uses partial day equivalencies.

Accordingly, providing additional clarity regarding the application of parity in these circumstances will help the affected parties to understand and follow the Rules.

III. Clarification of Exemption For Small Employers

The MHPAEA exempts small employers (and issuers offering coverage to small employers) from compliance with the new parity requirements. The Rules provide that a small employer is one "who employed an average of at least two but not more than 50

employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year" (unless applicable state law permits a single employee to constitute a small group). This definition of a small employer does not take into consideration the number of hours worked by each employee. California is one of several states that define a "small employer" based upon its number of "eligible employees," as determined by the number of hours worked by each employee.[1] California law provides special protections (e.g., guaranteed issue of coverage and rate limitations) for small employers as defined under California law. The differing California and federal definitions of "small employer" mean that some small employers under California law will not be eligible for the small employer exemption under the MHPAEA because they employ more than 50 employees in total (eligible and ineligible). These employers are considered small employers for state law purposes, but also large employers subject to the federal MHPAEA requirements. This creates potentially confusing and costly administrative burdens on employers and for health plans offering coverage in the small group market.

For clarity and ease of administration, further consideration should be given to amending the Rules to apply the small employer exemption to employers that qualify as small employers under applicable state laws, or to otherwise address these differences between state and federal law.

IV. Clarification With Examples for Non-Quantitative Treatment Limitations

In the Rules, the Departments specifically requested comments as to whether additional examples would be helpful to illustrate the application of the non-quantitative treatment limitation rule to other features of medical management or general plan design. Additional examples would be helpful to illustrate the application of the special rule for non-quantitative treatment limitations. Examples applying the Rules to health plans that impose any non-quantitative treatment limitations to all specialist benefits (e.g., prior authorization required to visit any specialist, but no authorization required for a primary care physician) would be particularly useful, as group health plans and issuers frequently structure benefits in this manner.

V. Clarification of the Effect of Federal Health Care Reform

These Rules were issued before the passage of the Patient Protection and Affordable Care Act. (PPACA, Pub. L. 111-148.) The PPACA contains provisions that directly amend the Public Health Service Act provisions of the MHPAEA, expanding the applicability of the parity requirements to "health insurance issuer[s] offering group or individual health insurance coverage." (PPACA, sec.1562 (c)(4).) Accordingly, further consideration should be given to amending the Rules to clarify the applicability of the MHPAEA and these Rules, and to specify any applicable timeframes.

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[1] California Health and Safety Code section 1357, subdivision (b). See Appendix I.

Thank you for this opportunity to comment on the proposed Rules. Should you have questions, please do not hesitate to contact me at 322-2012 or www.cehnes@dmhc.ca.gov.

Sincerely,

Lucinda A. Ehnes

Lucinda A. Ehnes, Esq.
Director
California Department of Managed Health Care

TP:tp

Enclosed: Appendix I

APPENDIX I

California Health and Safety Code § 1357.

(b) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.
(B) The employer offers the employees health coverage under a health benefit plan.
(C) All similarly situated individuals are offered coverage under the health benefit plan.

(2) Any member of a guaranteed association as defined in subdivision (o).

[...]

(*l*) "Small employer" means either of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a

small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.