COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

May 28, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653, United State Department of Labor
200 Constitution Avenue NW,
Washington, D.C. 2010
Attn: MHPAEA Comments

Community Health Plan of Washington is submitting these comments to 26 CFR Part 54 regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Community Health Plan provides managed care for more than 240,000 individuals and families throughout Washington who are enrolled in public programs, including Medicaid, CHIP and Medicare Advantage. The health plan's delivery system includes over 300 primary care clinics, 1,600 providers, 89,000 specialists and 90 hospitals. All cost savings created through our managed care programs are reinvested in community health centers in rural and urban communities across Washington.

Washington State first enacted mental health parity in 2005, and amended the law in 2008 to expand the requirements. While Washington State's law is considered to be more robust than the federal mental health parity law, there are some key differences:

- *Mandate:* Washington State requires mental health to be offered under insurance.
- *Substance abuse:* Washington State does not include substance abuse under the mental heath parity law.
- *Public programs:* Washington State law applies to the state-funded Basic Health insurance program for low-income workers, but not to Medicaid or Medicare; federal law applies to Medicaid managed care plans (including SCHIP).
- *Cost exemptions:* Washington State does not allow any cost exemptions for health plans.
- *Prescription drugs:* Washington State law requires that prescription drug coverage for mental health services equal that of any other prescription drug coverage.

Due to these differences between the federal mental health parity law and Washington State's mental health parity law, the precise impact that MHPAEA will have on our state and our health plan remains unclear. It appears that MHPAEA would require Medicaid

managed care plans to provide mental health parity for both mental health and substance abuse services. We are awaiting direction from the Washington State Department of Social and Health Services on this subject. It is unclear if MHPAEA would also apply to a state-funded public health insurance program, Basic Health. This program currently adheres to the definition of mental health parity under the Washington state law, which excludes substance abuse. Our comments assume that there will be changes for our organization and providers across the state based on the discrepancies between our state law and the federal mental health parity law.

A. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

i. What policies, procedures, or practices of group health plans and health insurance issuers may be impacted by MHPAEA?

MHPAEA would require a change to all of our Utilization Management policies/desk procedures, benefit grids, training programs for Customer Service Representatives, credentialing and Third Party Administrator claims processing guidelines. Additional information will also need to be shared with providers, hospitals, and members.

What direct or indirect costs would result?

Community Health Plan would incur costs due to the re-development of member education materials, provider education materials, staff time for development of materials, manager time for policy and procedure revisions, increased staffing for clinical reviewers for increased utilization, possible need to hire a staff/contract psychiatrist, increased claims for increased utilization, and increased costs due to lower patient cost shares for mental health and substance use disorders.

What direct or indirect benefits would result?

We expect there to be many benefits from MHPAEA, depending on how it interplays with Washington State's mental health parity law. Primary care providers will have a reimbursement incentive to staff mental health and behavioral providers in their offices to facilitate integrated delivery system care for mental health and substance use disorder treatment. Members will be more inclined to use mental health services once the cost and treatment structure is less cumbersome. Better integration for mental health and substance use disorder treatment with routine medical treatment is likely to result in better overall health outcomes for our members.

Which stakeholders will be impacted by such benefits and costs?

Members, family members, primary care providers, clinic office staff, specialists, hospitalists, hospitals, treatment programs and behavioral health providers will all be impacted by MHPAEA. It is unclear at this time how they will be each be impacted, but we expect people to have improved access to mental health and substance abuse services.

ii. *Are there unique costs and benefits for small entities subject to MHPAEA (that is, employers with greater than 50 employees that maintain plans with fewer than 100 participants)? What special consideration, if any, is needed for these employers or plans? What costs and benefits have issuers and small employers experienced in implementing parity under State insurance laws or otherwise?*

As a health plan which currently only offers public programs, we do not know what the impact will be on small employers.

iii. *Are there additional paperwork burdens related to MHPAEA compared to those related to MHPA 1996, and, if so, what estimated hours and costs are associated with those additional burdens?*

We are unclear about the administrative burden change since we are unclear about the interplay of MHPAEA with state law. We anticipate that there will be some additional burdens for mental health and substance use disorder treatment, in the form of reviews, claims, payments and credentialing.

B. Comments Regarding Regulatory Guidance

1. *The statute provides that the term "financial requirement" includes deductibles, co-payments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit. The statute further provides that the term ``treatment limitation'' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Do plans currently impose other types of financial requirements or treatment limitations on benefits?*

Currently Community Health Plan only allows certain treatments for mental health services due to underlying medical conditions. Impotence treatment and nutritional counseling are two examples of this. Both of these services are covered if the cause is medical but not if the cause is psychological. There is no consideration made for mental health or substance use disorder causes. For example, impotence can have a medical cause (blood flow to the penis), a psychogenic cause (damage to the frontal lobes of the brain), a psychological cause (male erectile disorder), or substance use cause (steroid use or abuse.) Only the medical and psychogenic causes are covered.

How do plans currently apply financial requirements or treatment limitations to medical and surgical benefits and mental health and substance use disorder benefits?

See above.

Are these requirements or limitations applied differently to both classes of benefits?

Yes. See above.

Do plans currently vary coverage levels within each class of benefits?

Yes. See above.

2. *What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?*

- When referencing "plans", does this also apply to Medicare itself (which lists a 190 day lifetime limit on inpatient psychiatric hospitalizations?)
- Does mental health include health coaching, disease counseling, genetic counseling, forensic examinations, court-ordered services, health education, wellness programs, neuro-developmental testing and therapy, pain management, and transplant counseling / work-up?
- Do smoking/tobacco cessation or methadone treatment count as substance use disorder treatment?
- Can states dictate programs which require different treatment, payment, etc. for these issues? (For example, can Washington state require Medicaid managed care members to use the Regional Support Network rather than the member's health benefit?)
- Are trichotillomania-caused alopecia, developmental disabilities, obesity/eating disorders, and gender identity disorder (leading to sexual reassignment surgeries) covered now because they are all legitimate mental health disorders according to the fourth edition of the Diagnostics and Standards Manual (DSM-IV-TR)?

3. *What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?*

Community Health Plan makes no differentiation with respect to criteria for medical necessity determinations with respect to mental health or substance use disorders. Milliman's Care Guidelines(TM) and Community Health Plan's own guidelines are used

for all enrollees in all situations equally. These guidelines are available for all enrollees and providers upon request.

4. *What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?*

Community Health Plan does not differentiate in our denial, approval, or lack of information processes, except where required by contract (but not with respect to mental health/substance abuse). We distribute these letters via fax to providers and facilities, and via mail to members. We follow all industry standards and contractual requirements per State and Medicare regulations.

5. *To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?*

Community Health Plan does not have coverage differences for out-of-network providers based on mental health or substance use disorder, aside from regional availability. This standard is also applied to medical services.

6. *Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to Federal agencies, State agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?*

Clarity around the health plan exception requests would be very beneficial. Currently, it is not altogether clear in the law and the analysis provided which plans would qualify for the exception. Everyone has annual cost increases higher than 2%, so it is unclear what constraints would be established to narrow down this exemption policy.

Since the Secretary's report will need to be filed every two years, will there be any additional reporting requirements for the plans? If so, will there be any type of work group which the health plans can participate in which will assist in the development of these reporting requirements?

Thank you for your time and attention in considering our comments.

COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

Sincerely,

Molly Belozer
Senior Government Affairs Analyst
Community Health Plan/Community Health Network of Washington
206-515-7983 (direct)
206-521-8833 (general)
206-521-8834 (fax)
molly.belozer@chnwa.org

Mike Hays, MSW, MHA
Manager, Care Coordination and Behavioral Health
Community Health Plan
Direct phone #: (206) 613-8897
General phone #: (206) 521-8833
Fax #: (206) 521-8834
michael.hays@chpw.org