



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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The Honorable Timothy Geithner
Secretary, U.S. Department of the Treasury

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services

The Honorable Hilda Solis
Secretary, U.S. Department of Labor

By Electronic Mail

**Re: Comments on Interim Final Rules Under the Paul Wellstone and Pete
Domenici Mental Health Parity and Addiction Equity Act of 2008**

Dear Mr. and Mmes. Secretary:

The Blue Cross Blue Shield Association (“BCBSA”) appreciates the opportunity to provide comments to the Departments of Labor, Treasury, and Health and Human Services (the “Departments”) regarding the Interim Final Rules (the “Regulation”) under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “Act” or the “MHPAEA”). 75 Fed. Reg. 5410 (Feb. 2, 2010). BCBSA represents the 39 independent Blue Cross and Blue Shield Plans (“Plans”) that provide health coverage to nearly 100 million – one in three – Americans.

As key stakeholders affected by the Regulation, Plans are committed to implementing the Regulation and to continuing to assist the Departments in developing reasonable and administrable standards for the provision of mental health and substance use disorder benefits to group health plans. BCBSA is filing these comments in response to the Departments’ request for comments on the Regulation as issued in the *Federal Register* on February 2, 2010. Our comments include specific recommendations for changes to the Regulation, as well as requests for clarification on particular areas of the Regulation.

BCBSA partnered with leading business, insurance, and mental health advocacy groups to work with Congress to enable the Act's passage. Clearly, the intent of the Act is to ensure that individuals do not face treatment or financial limitations that are more restrictive than those for medical and surgical services. However, BCBSA believes that Congress also intended to protect the ability of health insurers and sponsors of group health plans to establish benefits and manage services to ensure that members and purchasers receive value for their health care dollar.

More specifically, we are very concerned that, without a modification to the "substantially all" test, many health plans will be forced to make changes in benefit design, such as replacing copays with coinsurance for medical/surgical benefits and mental health/substance use disorder benefits ("MH/SU"). We are also concerned that some aspects of the Regulation inadvertently restrict the ability of insurers and group health plans to manage mental health and substance use disorder benefits and likely will drive up health plan costs.

To address these as well as other issues, we recommend the following:

- **Delaying the applicability date of the Regulation** in light of the major new requirements envisioned by the Regulation and enactment of the Patient Protection and Affordable Care Act (the "PPACA");
- **Ensuring an adequate transition to parity within the individual health insurance market** by clarifying that these provisions are not effective until 2014 when exchanges become operational;
- **Ensuring that the "substantially all" and "predominant" tests do not undermine popular benefit designs** by imposing inflexible requirements that could result in adverse changes to coverage for medical and surgical conditions simply to comply with the Regulation;
- **Eliminating the Regulation's "non-quantitative treatment limitations,"** which create considerable uncertainty with regard to the use of managed care tools to control costs, a key condition of the negotiations that enabled the enactment of the MHPAEA; and
- **Maintaining the Regulation's existing treatment with regard to scope of services,** which appropriately allows plans the flexibility to limit treatments and treatment settings as envisioned in the MHPAEA.

We urge the Departments to consider a more flexible approach to successfully meet the goals of the Act to ensure quality care as well as maximum value for health plan members. We provide our detailed comments on these and other important issues below.

I. Request for Delay in Applicability Date

BCBSA requests that the Departments delay the applicability date of the Regulation until the first plan year beginning on or after July 1, 2011. A delay in the applicability date is well justified since the July 1, 2010 date provides health insurance companies that issue

and renew policies throughout the year with less than five months to analyze the Regulation and prepare changes to policies, many of which require prior approval by state insurance departments. Moreover, many of the provisions of the Regulation, including the non-quantitative treatment limit rule and the “substantially all”/”predominant” tests, could not have been anticipated by Plans prior to the issuance of the Regulation. As such, compliance is more difficult than expected. Finally, numerous significant changes have been made to the law under health care reform that also must be fully analyzed.

At a minimum, the Departments should delay the Regulation so the impact of the recently enacted PPACA can be fully considered. For example, under new section 2713 of the Public Health Service Act (“PHSA”), established by the PPACA, individual and group insurance coverage and group health plans are required to cover preventive care services with no cost-sharing. This rule applies to “non-grandfathered” coverage and plans for plan years beginning on or after September 23, 2010. This new requirement alone will impede the ability of health plans to apply cost sharing to mental health and substance use disorder benefits under the Regulation’s “substantially all” and “predominant” tests. In addition, section 1562 of the PPACA (conforming amendments) extends the MHPAEA to individual insurance policies and increases the size of small employers for which the small employer exemption is available from 50 to 100 employees for purposes of the PHSA (see sections 2726 and 2791 of the PHSA) without a specific conforming change in the small employer size under ERISA or the Internal Revenue Code. It is unclear when these substantial changes are effective.

These factors could not have been considered when the Departments issued the Regulation as an interim final rule. In connection with a delay in the applicability date, BCBSA requests continuation of the good faith compliance period as Plans analyze the Regulation and PPACA and come into compliance with its requirements. Plans have already made changes to their policies to comply with the Act, but need additional time to come into compliance with the Regulation – particularly because of the regulatory environment in many states, which requires amendments be filed and approved in advance by the State insurance commission. If the Departments do not issue a general delay in the applicability date, BCBSA requests the simplifications set forth below (especially with regard to the “substantially all” test).

II. Application to the Individual Health Insurance Market

MHPAEA applied only to group health plans and did not impact the individual health insurance market. However, a provision in section 1562 of the PPACA (conforming amendments) extends the MHPAEA to individual insurance policies and does not include a specific effective date.

Our understanding is that this provision was adopted in an amendment proposed by Senator Stabenow during mark-up of the legislation. According to a press release from Senator Stabenow, the provision was intended to ensure that the new exchange plans comply with federal “parity” laws to provide coverage for mental health services that is equivalent to coverage provided for physical health services.¹

¹ Senator Stabenow’s press release can be found at: <http://stabenow.senate.gov/press/2009/122409SenatePassesHistoricLegislationtoReformHealthInsuranceToSaveLivesSaveMoneyandSaveJobs.htm>

It is unlikely Congress intended this provision to be effective immediately. First, under the PPACA, Exchanges will not be operational until 2014. Second, the MHPAEA provided a year delay in the effective date for group health plans and then provided that the new requirements would apply to new plan years to provide time for large employers to comply with the Act. Third, Congress could not have reasonably envisioned making these changes effective in a timeframe that would not permit compliance.

We believe that the application of parity to the individual market is to be applicable in 2014. This is evidenced by the inclusion of "mental health and substance use disorder services, including behavioral health treatment" as an "essential benefit" that must be provided in all qualified health plans and all plans offered in the individual and small group markets in 2014. PPACA § 1302(b); amended PHSA § 2707(a). Additionally, section 1311(j) of the PPACA provides -

"APPLICABILITY OF MENTAL HEALTH PARITY - Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans."

This section, like the rest of 1311, is effective in 2014. This section appears to make clear that, in 2014, when individual policies must provide mental health services as part of an essential benefit package, the policies must be offered in parity. Arguably, this section wouldn't be necessary if the mental health parity rules were effective for individual policies prior to 2014 (and therefore already applied to individual insurance).

Application of the requirements of the MHPAEA to the individual health insurance market without a transition would entail substantial disruption. The individual market is composed of millions of insurance policies covering approximately 17 million people nationwide. Changes to these policies involve filing and receiving approval of changes with state health insurance regulators. It is not administratively feasible to comply with MHPAEA in the individual insurance market without a reasonable transition period.

We respectfully request clarification that these provisions are not effective until Exchanges are operational in 2014.

III. "Substantially All" / "Predominant" Tests (§ 2590.712(c)(3)(i))

The "substantially all" and "predominant" tests are unusually complicated and need to be simplified. Plans are gravely concerned about the cost impact of these tests and the design changes that would be required to pass these tests. Based on survey data collected by BCBSA, we believe that most products are failing these tests, which will potentially impact the benefits for tens of millions individuals.

The complexity is clear. The test must be calculated for every plan option (HMO, PPO, and indemnity) and every combination of options where there is a mental health/substance use disorder carve-out offered in tandem with HMO, PPO, and indemnity options. The test must be calculated for every type of financial requirement (coinsurance, copays, deductibles, out-of-pocket maximums) and for every level of such financial requirement. The test must be calculated for every type of treatment limit

(days, visits, episodes) and for every level of such treatment limit. The test must be calculated for each classification of benefits for every benefit plan option (inpatient to inpatient, outpatient to outpatient). The test must be calculated for every coverage type (employee, employee plus one, family) for every benefit plan option, entailing dozens of calculations for each benefit plan. Some Plans have more than 10,000 different benefit plans they believe are subject to compliance review. The cost of just performing such calculations could exceed \$1 million for an average-sized Blue Cross and Blue Shield Plan.

In addition to administrative cost and complexity, the “substantially all” tests need to be modified to avoid unintended and negative impacts on plan benefits offered to plan participants. Under these tests, in order for any type of financial requirement (or treatment limit) to apply to mental health/substance use disorder benefits, that particular “type” of requirement must first apply to two-thirds of the medical/surgical benefits within a particular classification. This test may not be met for many plans for either copays or coinsurance, even though substantially all of the medical/surgical benefits in that category are subject to some cost sharing.

The reason the “substantially all” test is not met with some frequency is that Plans do not uniformly use copays or coinsurance in a particular category – Plans seek to incentivize certain behavior as a measure of cost control as well as encourage certain wellness-related behaviors. Indeed, many Plans exempt certain types of preventive care or wellness visits from cost-sharing altogether. For example, well-child visits may be provided at \$0 copay or coinsurance or office visits for diabetes care may be offered at a reduced copay. This is obviously beneficial to plan members.

A survey of Blue Cross and Blue Shield Plans indicates that a majority of products are failing the “substantially all” test. **Based on responses from twenty Plans, the median number of products failing the tests is 74%. Although testing has not been completed by all Plans reporting data, at least 118,530 employer group and 18,329,324 members have plans that do not meet the test as set forth in the Regulation.** In most cases, the problems concern the outpatient category, although problems have been identified with other categories as well.

The following examples from Blue Cross and Blue Shield Plans further illustrate the problems with the test as currently drafted:

Plan A: “We believe our plans currently meet the original intent of the Federal Statute. Our plans treat MH/SA and medical/surgical the same for a given classification (office visit copays are the same for MH/SA as for any other specialist; an inpatient stay, medical/surgical or MH/SU, is subject to the same overall deductible, coinsurance percentage, and coinsurance maximum for example). Having to apply the “substantially all” and “predominant” tests within designated classifications in the regulation has the unintended consequence of steering plans AWAY from parity. For example, if deductible and coinsurance become the “substantially all” financial requirement with the outpatient, in-network classification, then MH/SA services subject to copay today will have their benefit REDUCED because of the tests and will be subject to deductible and coinsurance.”

Plan B: “Upon evaluation of the Interim Final Rules and the effects it is creating for our business, approximately 50% of our plans fail, causing us to change benefits for

more than 100,000 members in our fully insured plans and more than 700,000 members in our self insured plans. We do not believe this was the intent of the Rules, especially because our plans consistently cover MH/SU services the same as any other service.... The outpatient classification, as traditionally defined by the industry and in our contracts is a very broad category that includes many different types of cost sharing arrangements. The reason our plans are failing is solely based on the fact that variations in cost sharing exist within the outpatient classification. 92% of the plans that fail are failing for copays (and some of these plans also fail for deductible and/or coinsurance). 8% of the plans that fail are failing due to coinsurance and/or deductible only.”

The above examples illustrate the significant issues Plans are encountering with the “substantially all” and “predominant” tests, particularly with popular products that emphasize the use of copays for office visits.

In addition, the outpatient classification is too broad, and in practice, is a catch-all for plan costs that do not fit into one of the other specified classifications. Because so many services – and even products – are included in the outpatient classification, it makes passing the substantially all test very difficult with regard to financial requirements (i.e., cost-sharing) imposed on mental health benefits. For example, Plans often but not always apply coinsurance to facility charges, including facility charges associated with outpatient coverage. However, Plans typically apply copays for provider/professional charges. In such circumstances, most outpatient coverage is subject to cost-sharing, but in many cases neither type of cost-sharing (coinsurance or copays) would meet the two-thirds test as discussed below.

As a result of the substantially all test, many health plans will have to modify their medical/surgical benefits so that copays or coinsurance will apply to two-thirds of the medical/surgical benefits in a particular classification. This will negatively impact participants by driving up their out-of-pocket costs for medical/surgical benefits, creating a barrier to those seeking care.² Alternatively, health plans will have to eliminate cost-sharing for mental health/substance use disorder benefits, which will drive up the costs of mental health/substance use disorder benefits, or they will narrow the scope of mental health/substance use disorder benefits. The problems with this test may also cause more employers to drop coverage of mental health services.

BCBSA believes that these results are unintended consequences of the substantially all test and the narrow set of classifications permitted under the Regulation. To address these unintended consequences, and to generally ease compliance burdens associated with the test, BCBSA recommends the following:

- Subclassifications should be allowed if necessary to pass the two-thirds test. Allowing outpatient benefits to be divided between facility charges and provider/professional charges is a good example. The Regulation should be modified to allow Plans to use other legitimate subclassifications for comparing

² As an example, one Plan currently offers a "copay" rider to groups for an extra premium for outpatient provider charges. That copay rider, when elected, causes such policies to fail the substantially all test. As a result, the copay rider may be discontinued and only coinsurance may be available for office visits so that coinsurance can be applied to mental health/substance use benefits.

medical/surgical benefits to mental health/substance use benefits, including facility charges, provider charges, types of providers (primary versus specialist; physician versus other professionals), durable medical equipment (“DME”), and therapists.

- Plans should be allowed to exclude services that are provided with no cost-sharing or at reduced cost-sharing from the substantially all test, particularly if offered to encourage wellness. This is particularly important since PHSA section 2713, added by PPACA, mandates coverage of certain preventive services without cost sharing for plan years beginning 6 months after PPACA's date of enactment.
- The final Regulation should clarify that amounts paid by the participant (copays, deductible, coinsurance) are included in the calculation of the “substantially all” and “predominant” tests. If a Plan is using prior year data to perform the parity tests, it may be difficult to separate cost-sharing amounts from the calculation of plan costs. And including these amounts provides total costs for the services, which gives a more accurate prediction of future plan costs which may have a different cost-share structure.
- Plans should be allowed to develop an "actuarial equivalence" for cost-sharing in a particular classification that would take into account copays and coinsurance and an actuarially equivalent cost sharing should then be permitted for mental health/substance use, regardless of the type of cost-sharing. This would allow a blend of copays and coinsurance on the medical/surgical side, without imposing a significant financial burden to members seeking mental health services (i.e., coinsurance).
- Guidance should be given on how frequently a plan must perform the calculations. As noted above, the calculations are very complicated and reducing the frequency of the calculations would relieve the administrative burden associated with compliance. The Regulation should provide that the calculations do not need to be repeated every year absent changes in plan design or indications that assumptions were wrong or data is not accurate.
- Examples should be provided with illustrations of actuarial methods that health plans may use to estimate costs, but the guidance should provide that any method approved by an actuary as reasonable is permitted.

IV. Non-quantitative treatment limits (§ 2590.712(c)(4))

One of the most unexpected requirements of the Regulation is the requirement for parity for non-quantitative treatment limits. Early legislative versions of the Act included parity rules for medical management, but those rules were not included as part of the final Act.³ Indeed, the Act only contemplates easily quantifiable treatment limits. As such, BCBSA urges the Departments to eliminate this aspect of the Regulation in its entirety.

³ Add note re legislation.

A. Medical Management

Our understanding is that the category of non-quantitative treatment limitations, which include medical management, was created in response to comments submitted by mental health advocates who equated medical management with denial of access to services they argued were de facto treatment limitations.

Medical management is an important tool in assuring appropriate use of services and assuring that our members receive high quality care. Our Plans have reported that they use medical management to drive quality improvement and assure appropriate care for their members. For example, Plans reported that they have programs to improve medication compliance and identify members with specific conditions that may benefit from medication and refer them to appropriate physicians for re-evaluation. They also have programs where they attempt to intervene and seek the appropriate level of treatment (up to and including inpatient) to prevent severe physiologic dysfunction and prevent disruptions in benefits during a course of treatment.

The majority of companies that manage mental health/substance use conditions utilize medical management processes that are based on national accreditation standards. NCQA, which is an accrediting organization for managed care organizations, requires in its Managed Behavioral Health Organization (MBHO) Standard, Utilization Management 2, that medical management processes are developed based upon written criteria that is based on sound clinical evidence. These criteria are objective, evidence based, and take individual circumstances and local delivery systems into account when determining appropriate health care services. Behavioral health practitioners are involved in developing, adopting, and reviewing these criteria. The criteria are reviewed at least annually and updated when appropriate. NCQA MBHO Standard, Utilization Management 4, also requires that behavioral health practitioners from the appropriate specialty area are used to make medical management decisions.

URAC is the other accrediting body for managed care organizations and has similar requirements. Therefore, organizations that are accredited by either NCQA or URAC, or that comply with these criteria even if not accredited, are certainly using medical management processes that are clinically justifiable.

In practice, medical management processes for mental health/substance use disorders are typically used to determine the appropriate level of care for persons with mental health/substance use conditions, not whether treatment is needed. In behavioral health, there is a legal principal known as the "least restrictive environment" which many States have also adopted by statute. As a result, there is an emphasis on limiting the number of days that a person has to be hospitalized. The treatment goal is to determine when it is appropriate to transition the person to an intermediate level of care, such as partial hospitalization or intensive outpatient treatment.

Management of mental health/substance use disorders is based on unique and different purposes from those needed for medical/surgical conditions. Most patients receiving treatment for mental health/substance use disorders are receiving treatment from multiple clinicians. A primary care physician, a psychiatrist, and a behavioral health therapist may all be involved in treating the person. One of the goals is to ensure that there is appropriate coordination of care. Another purpose is verifying that the person is receiving the appropriate care that is needed. For example, if a patient has seen a

behavioral health therapist for an extended length of time and there is no indication that the patient's condition is improving, case managers analyze whether medications have been prescribed and are being taken, or whether perhaps medications are needed, or whether the person needs to be treated in a higher level of care. Managing mental health/substance use disorders results in more appropriate access to services, increased quality of care, and better treatment outcomes.

A health plan's approach to medical management in the outpatient setting is also often dependent on provider type. For example, many Plans use a brief notification system when the treating provider is a physician/psychiatrist. However, Plans require more information from a non-physician provider such as a licensed counselor or psychologist to certify medical necessity for treatment/services. This practice is congruent to that employed on the medical/surgical management side, where the treating physician typically does not need to obtain pre-certification for outpatient care, while ancillary clinicians such as occupational and physical therapists are subject to closer scrutiny.

The treatment of many mental health conditions/substance use disorder conditions is more uncertain than for medical/surgical benefits, and medical management tools are utilized to ensure the treatment is appropriate for a particular patient – not to impose arbitrary limits on treatment. These initiatives sometimes focus on outliers. The behavioral health literature indicates the mean number of times a patient visits a non-physician provider for the treatment of a mental health condition/substance use disorder is approximately six visits. If the number of visits is substantially higher, there may be a need to manage the benefit.

We believe that the intent of this Regulation is not to increase medical management for medical/surgical conditions, which would result in the unintended consequences of placing more limitations upon those with medical/surgical conditions. We request that, if the nonquantitative treatment limitation rule is not eliminated, this Regulation be clarified to provide such that any medical management processes merely need to be clinically justifiable. If the final Regulation retains the concept of parity for "non-quantitative" limits, the provision should be narrowed so that any non-quantitative treatment limit is truly "similar" to a day or visit limit as contemplated by the Act's statutory language. The provision could be narrowed so that it only addresses medical management programs that (1) are subterfuges for a quantitative limit (e.g., the utilization review program will never authorize more than 10 counseling sessions); or (2) facially discriminatory (e.g., there is only retrospective review for medical necessity for outpatient medical/surgical but all outpatient mental health/substance use is subject to preauthorization).

B. Provider Access and Reimbursement

In addition to the provisions requiring parity for medical management, BCBSA is also concerned with the provision in the non-quantitative treatment limit rule that relates to provider network adequacy and admission standards. BCBSA believes that these criteria are simply not a treatment limit that is "similar" to a day or visit limit as contemplated by the Act.

First, Congress specifically rejected network adequacy rules. Moreover, these rules are not needed since States already regulate provider networks for insured business and health insurers often use the same networks for their insured and self-insured business. For example, the state of Michigan requires that plans submit provider qualification

requirements, reimbursement arrangements, and provider contracts to the state insurance commissioner before the plan is allowed to implement. In addition, a variety of accrediting bodies, such as URAC and NCQA, already establish standards for health plans that address the adequacy of networks.

Finally, BCBSA requests that the provisions that require parity in provider reimbursement or UCR charges be dropped from the Regulation. These criteria are simply not a treatment limit that is in any way "similar" to a day or visit limit, nor is it relevant to the policy behind the Act.

The goal of the Act is to provide mental health and substance use benefits in parity to patients – not to provide parity (i.e., increases) in payment to providers. Compliance with these provisions would be particularly onerous. A typical Plan has contracts with 80% of licensed physicians in the United States. There is no way that Plans can review thousands of provider agreements by July 1, 2010. In addition, if a Blue Plan provides medical/surgical benefits, but a separate carve out vendor provides mental health/substance use services, there is no way the plan sponsor (or the Blue Plan) could assure parity as to provider reimbursement or UCR charges.

V. Scope (§ 2590.712(e)(3))

The Regulation currently provides that it does not affect plan terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits except as specifically required under the parity requirements with regard to lifetime and annual limits, financial requirements, and treatment limitations. 29 C.F.R. § 2590.712(e)(3)(ii). The preamble to the Regulation requests comments on the scope of the Regulation. 75 Fed. Reg. at 5416-17. In particular, it appears the Departments are considering whether the Regulation should establish some standards regarding the coverage for certain treatments or treatment settings where a plan or policy covers a particular mental health or substance use condition. BCBSA opposes revisions to the Regulation that would mandate the scope or continuum of care and notes this is one of the few means by which health plans can control the cost and quality of mental health and substance use disorder benefits in light of the limits placed on medical management by the non-quantitative treatment limits provision of the Regulation as discussed below.

Additionally, appropriate measurements regarding available treatments or treatment settings are intended to benefit the patient through encouraging the delivery of safe, high quality and effective care. Plans regularly have mental health clinicians and other experts review various treatments and treatment settings to ensure patients are offered clinically appropriate care by licensed healthcare professionals under the plan design. There is an enormous variety in the treatments and treatment settings available for mental health conditions and substance use disorders – and it is widely documented that not all of these treatments or treatment settings are clinically appropriate or effective, or are even available through licensed providers. This is in contrast to overall medical and surgical treatments which typically follow relatively-standardized treatment protocols in licensed medical facilities from licensed providers. For example, many plans exclude substance abuse treatments such as wilderness programs or boot camps that do not have licensure or a proven success rate.

The Regulation has adopted the right scope in 29 C.F.R. § 2590.712(e)(3)(ii) and appropriately allows plans the flexibility to limit treatments and treatment settings for

otherwise covered mental health/substance use conditions. Plans need this continued flexibility to continue to determine the scope of services covered to treat a particular mental health condition or substance use disorder based on factors such as current standard medical practice, licensure, available clinical evidence regarding the efficacy of a particular treatment or treatment setting, and other factors. Further regulation and guidance on this is not needed and would drive up health plan costs and eliminate the flexibility that Congress intended.

VI. Applicability/Single Group Health Plan Rule (§ 2590.712(e)(1))

It is common for a single employer group health plan to offer employees the option of enrolling in either an HMO or a PPO option. It is also common that the mental health/substance use benefits provided under the HMO or PPO option are provided by the same vendor and not by a carve-out mental health/substance vendor. The Regulation eliminates the provision in the prior mental health parity regulations that made clear that parity is analyzed on a benefit package by benefit package basis. The Regulation (in paragraph (e)(1)) provides that the plan has to test all combinations of benefits that an employee can simultaneously receive for parity and treats all such combinations as a single group health plan. This rule supplies a testing rule for when plans offer mental health/substance use options separately from medical/surgical options and clearly eliminates the possibility that a plan could carve out mental health/substance use benefits into a separate plan and circumvent the rule.

The Regulation should clarify, however, that in a simple example of an HMO and PPO option being offered under a single plan, and where there is no carve out vendor for mental health/substance use, the testing would still occur separately within the HMO option and the PPO option. Plans would not have to combine both options for purposes of testing since employees can only enroll in one or the other at any given time (an individual could not simultaneously be in the HMO and PPO). Otherwise, the offering of an HMO may require that enrollees in the PPO get the lower HMO copays if the predominant copays for the HMO and PPO combined turned out to be the HMOs.

The Regulation should also specifically confirm that, if a Plan offers mental health and substance use disorder benefits in all classifications and also offers an overlay of, for example, additional mental health services provided through an EAP or additional substance abuse services offered through a wellness program, the EAP or wellness program would not be subject to the parity requirements.

VII. Requiring Coverage in All Classifications (§ 2590.712(c)(1)(ii))

The Act requires that out-of-network coverage for mental health/substance use benefits be provided under a Plan if out of network coverage is provided for medical/surgical benefits. However, the Act does not include any requirement mandating coverage for all categories of benefits. The Regulation goes beyond the Act to require that if mental health/substance use benefits are covered in any classification, mental health/substance use disorder benefits must be covered in all classifications. The preamble expands this rule even further by suggesting that a particular condition or disorder that is covered in one classification must be covered in all classifications for which medical/surgical benefits are provided, or the exclusion in certain classifications could be considered a treatment limitation. 75 Fed. Reg. at 5413.

In other words, if a plan expects to exclude coverage of mental health or substance use disorder conditions, it must do so in all classifications – including prescription drugs. However, primary care providers often diagnose mental disorders, drugs are prescribed that can be used for multiple uses (e.g., medical or mental health), and emergency services are often covered for substance use or mental health emergencies. For example, Valium is approved by the FDA to treat anxiety disorders and alcohol withdrawal, but is also used to treat seizures and as a muscle relaxant. As a practical matter, this provision of the Regulation could have unintended consequences – either plans will eliminate certain basic or emergency services or prescription drugs for mental health and substance use disorder services or plans will not be able to permanently exclude mental health or substance use disorder benefits, as specifically permitted under the Regulation. This creates an additional issue with regard to prescription drugs. Plans may decide to exclude dual-purpose drugs which would deny patients coverage of drugs like Xanax that are very effective for treating medical conditions. It would be cost prohibitive for a plan to review the condition for which a drug is prescribed. As such, this provision should be eliminated in the issuance of a final Regulation.

VIII. Cost Exemption

The cost exemption in the Act permits plans to apply for a one year cost exemption, if, after six months, the plan can show that the application of the parity requirements resulted in an increase in total plan costs of two percent in the first year and one percent in subsequent plan years. ERISA § 712(c)(2). At the end of the six month period, the plan must obtain a written actuarial determination from a qualified and licensed actuary. The determination must be based on "actual total costs of coverage" attributable to the application of the parity provisions to the plan. Although the determination is done for an initial six month period, it appears that plans must comply with the law for the rest of the plan year. ERISA § 712(c)(2) ("the provisions of [the Act] shall not apply to such plan (or coverage) during the following plan year . . ."). It then appears that plans must come back into compliance with the Act in the subsequent year because any exemption is expressly limited to one plan year. ERISA § 712(c)(2).

We note that it would be extraordinarily difficult and costly for employers to administer this exemption and for participants to understand a group health plan that shifts in and out of compliance each plan year according to the Act's parity requirements. Employers would be required to redesign their plan every single year in order to comply with the cost exemption requirements. Participants would be unable to rely on their plan benefits and therefore plan lengthy treatments because their plans will be redesigned every year. We recognize the Departments are bound to a certain extent by the language of the statute. Nevertheless, we are requesting guidance that would simplify the cost exemption, as follows.

- Once the cost exemption is met with actual total costs of coverage by a particular plan, an actuary can make a projected determination of total cost of coverage for subsequent plan years. To read the cost exemption otherwise would make the exemption virtually unavailable to employers because it would be too difficult to administer (and make it more likely that the employer would terminate all mental health and substance use benefits).

- "Cost" should include not only claims experience, but also administrative costs associated with complying with the parity requirements.
- The previous regulations confirmed that the cost exemption would be calculated based on the incurred expenditures at the individual group level, but provided a special rule for plans in a rating pool. Group health plans/policies that are combined in a pool for rating purposes could therefore satisfy the cost exemption based on the incurred expenditures of the pool, even if all the plans in the pool did not participate in the pool for the entire base period. However, only the plans that have complied with the parity requirements for six months could take advantage of the cost exemption. We are requesting that the agencies adopt the special rating pool approach used in the regulations interpreting the cost exemption of the 1996 Act.
- We request that, in adopting the special rule for pool rated plans (as discussed above), the Departments clarify that for experience and pool rated plans, if the majority of the premium rate is based on the pooled rate, the plan is able to satisfy the exemption using the special rule.
- The Departments should issue guidance regarding what claim expenses are included in the cost comparison for the cost exemption. The previous regulations provided that the cost exemption calculation was based on "incurred expenditures," defined as actual claims incurred during the base period (first 6 months of the plan year) and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits during the base period. 29 C.F.R. § 2590.712(f)(2) (1997). Incurred expenditures did not include premiums. 29 C.F.R. § 2590.712(f)(2)(iii) (1997). The approach taken by the regulations in interpreting incurred expenditures for the 1996 Act should be adopted in the final Regulation implementing the increased cost exemption for the Act, but also include prescription drug claims incurred and any administrative expenses related to parity requirement compliance. Further, plans should be permitted to estimate claims that have not yet been reported for purposes of the incurred expenditure calculation.
- Examples should be provided demonstrating how a plan would calculate the actual total costs of coverage under the plan as a result of the application of the parity requirements as opposed to other market conditions, or to comply with PPACA or state mandates.
- Guidance should be issued confirming that costs associated with good faith compliance with the Act prior to the applicability date of the Regulation may be included in the cost comparison for purposes of the exemption.

IX. Small Employer Exemption

Changes under PPACA have increased the size of the employer for whom the small employer exemption is available to employers with one to 100 employees for purposes of the PHSA. See PHSA §§ 2726, 2791. It appears, however, that the PHSA definition of small employer is not specifically incorporated into the parity requirements under

ERISA and the Code because ERISA section 715 and Code section 9815 do not incorporate by reference section 2791 (because it is not included in part A of title XXVII of the PHSa). As a result, the definition of small employer under ERISA and the Code would include employers with an average of two but not more than 50 employees on business days during the prior year. This creates an inconsistency for an employer who offers an insured plan that is covered by ERISA, the Code and the PHSa (with regard to the insurance issuer offering the policy). BCBSA requests guidance that incorporates the PHSa definition into ERISA and the Code, at least for purposes of insured plans, to resolve this inconsistency. Similar to the individual market rules, the small employer definition does not have a clear effective date from the language of PPACA. We request clarification that this provision is effective January 1, 2014. This definition has an impact on the small group rules as well.

BCBSA also requests guidance confirming that the small employer exemption will continue to provide relief from the parity requirements for small employers in the small group market, even after mental health benefits are required to be provided in the small group market in 2014, as discussed below. Beginning in 2014, PPACA requires insurers in the individual and small group market to provide essential benefits. Essential benefits include mental health and substance use disorder services. Further, also in 2014, qualified health plans (sold through an Exchange) must comply with the mental health parity requirements, but only to the same extent as the requirements apply to health insurers and group health plans. This means that beginning in 2014, health insurance in the small group market (within or outside an Exchange) will be required to provide mental health benefits. However, we would like confirmation that as long as the small employer exemption remains in the mental health parity provisions, small group insurance (within or outside an Exchange) that is considered to be provided by a small employer should not have to comply with parity requirements because (a) the small employer exemption is still in effect under the PHSa, ERISA and the Code (hopefully with a consistent definition, as discussed as above), and (b) for insurance offered through the Exchange. PPACA requires only that the mental health parity requirement apply to qualified health plans in the same manner as they apply to plans outside of the Exchange (which permit the small employer exemptions).

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Thank you for the opportunity to comment on the MHPAEA and for considering our suggested recommendations. We look forward to continuing to work with the Departments on implementation issues related to the Act. If you have any questions, please contact Kris Haltmeyer at 202.626.4814 or via email at kris.haltmeyer@bcbsa.com.

Sincerely,



Justine Handelman
Executive Director
Blue Cross Blue Shield Association