MAYER·BROWN

Mayer Brown LLP
1999 K Street, N.W.
Washington, D.C. 20006-1101

Main Tel +1 202 263 3000
Main Fax +1 202 263 3300
www.mayerbrown.com

Robert E. Bloch
Direct Tel +1 202 263 3203
Direct Fax +1 202 263 5203
rbloch@mayerbrown.com

April 30, 2010

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, D.C. 20210
Attn: RIN 1210-AB30

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
Attn: CMS-4140-IFC

Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, D.C. 20224
Attn: CC:PA:LPD:PR (REG-120692-09)

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

Dear Sir/Madam:

The following comments and recommendations are being submitted on behalf of Blue Shield of California ("Blue Shield") regarding the Interim Final Rules (the "Interim Rules") implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA" or the "Act")), Pub. L. 110-343, Div. C, Title V, Subtitle B (Oct. 3, 2008). In particular, Blue Shield is concerned that the Interim Rules' definition of what constitute "nonquantitative treatment limitations," in Section 2590.712(c)(4)(ii)(B)-(D), is overbroad in that it requires parity with respect to matters that are not necessary to achieving the Act's purpose of eliminating discrimination between medical and mental health/substance abuse benefits. Moreover, compliance with the Act's parity requirements regarding the items in subparagraphs (B)-(D) will require competing health plans to engage in exchanges of information, and reach agreements, regarding competitively sensitive matters that may reduce

competition and expose those health plans to potential antitrust liability. Blue Shield therefore recommends that subparagraphs (B)-(D) of Section 2590.712(c)(4)(ii) not be included in the Final Rules.

Background

A. Provision of Mental Health/Substance Abuse Benefits to Blue Shield Customers

Blue Shield of California is an independent member of the Blue Cross Blue Shield Association. Blue Shield is a not-for-profit health plan with 3.4 million members, 4,800 employees, and some of the largest provider networks in California. Blue Shield offers a wide range of commercial and government health insurance products (underwritten and self-funded) throughout California, including medical/surgical and mental health/substance abuse benefits.

Blue Shield's customers typically purchase medical/surgical and mental health/substance abuse benefits in one of three ways. First, the customer can contract with Blue Shield to provide both medical/surgical and mental health/substance abuse coverage through Blue Shield. Second, the customer can contract with Blue Shield for both coverages and Blue Shield can, in turn, sub-contract with a third-party licensed mental health plan to provide mental health/substance abuse benefits on behalf of Blue Shield. Blue Shield might do so, for example, where it can achieve administrative efficiencies by contracting with a third-party plan or where a third-party plan can provide a more comprehensive provider network to a particular customer. Blue Shield delivers mental health coverage for a substantial portion of its enrollment in underwritten plans using this approach. Third, the customer itself sometimes chooses to buy medical/surgical benefits through one company (e.g., Blue Shield), and to "carve out" and purchase mental health/substance abuse benefits through another insurer. This latter approach is more common with large, self-funded employers who contract with Blue Shield to administer only the medical portion of their health plan, but also is used by some employers in underwritten plans.

B. The MHPAEA and "Nonquantitative Treatment Limitations"

Broadly stated, the MHPAEA was enacted to mandate parity between medical/surgical benefits and mental health/substance abuse benefits. It achieves this by requiring that the financial requirements for mental health/substance abuse benefits (e.g., co-pays, deductibles), be "no more restrictive" than the "predominant financial requirements applied to substantially all" medical/surgical benefits. Likewise, treatment limitations for mental health/substance abuse benefits may not be "more restrictive" than the treatment limitations placed on medical/surgical benefits. "Treatment limitations," are defined by the Act to include "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." Section 512 (a)(1)(B)(iii). By enacting the MHPAEA, Congress's aim was to "equalize mental health and addiction benefits with other health benefits" and "to end insurance coverage discrimination for those seeking to access mental health and substance use disorder benefits through their health insurance provider." See Letter from Representative Patrick J.

Kennedy, et al., regarding Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (June 1, 2009).

Among other things, the Interim Rules define what constitute "treatment limitations." In addition to mandating parity in quantitative treatment limitations (e.g., number of visits), the Interim Rules require that "nonquantitative treatment limitations" be in parity between medical/surgical and mental health/substance abuse benefits. See Section 2590.712(c)(4). The Interim Rules go on to provide an illustrative list of nonquantitative limitations. These include:

"...

(B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

..."

Section 2590.712(c)(4)(ii)(B)-(D).

Analysis

It is difficult to see how requiring parity with respect to the items described in subparagraphs (B)-(D) advances the purposes of the MHPAEA to end discrimination with respect to "financial requirements" or "treatment limitations," both of which relate directly to the terms of member health plan benefits. In particular, the rates at which health plans reimburse providers and the criteria for health care provider participation in plan networks are not financial or treatment benefit terms and have no direct relationship to such terms. Requiring parity with respect to these "nonquantitative treatment limits" therefore appears to be beyond the scope of the Act as well as beyond any reasonable authority granted to promulgate regulations to achieve the purposes of the Act.

Moreover, inclusion of subparagraphs (B)-(D) in the Final Rules may have an adverse effect on competition, and expose health plans attempting to comply with these provisions to potential antitrust liability, by requiring coordination and agreement on terms of competition between competing plans. In the situations described above in which either Blue Shield subcontracts with a third-party mental health/substance abuse provider or its customer contracts separately with a third-party mental health/substance abuse provider, Blue Shield may be a direct competitor of the third-party health plan in the provision of mental health/substance abuse coverage. Further, most of these mental health/substance abuse providers are owned by health plans that compete with Blue Shield in the provision of medical/surgical coverage. In these situations, the Interim Final Rules, as currently written, require health plans to exchange information on terms (i.e., the terms covered by subparagraphs (B)-(D)) that insurance

companies consider competitively sensitive in order (1) to determine whether the medical benefits a plan is providing and the third-party mental health/substance abuse benefits are in parity, and (2) if parity does not exist, to reach agreement on these terms to bring the two plans into compliance. At the same time, a health plan often will be exchanging sensitive competitive information regarding its medical/surgical plans with the mental health/substance abuse affiliate of a health insurer with which it competes on medical/surgical coverage. Under the proposed rules as drafted, many U.S. medical insurance plans will find themselves in this situation if the requirements of subparagraphs (B)-(D) are adopted in the Final Rules.

There is no question that the matters covered by subparagraphs (B)-(D) are the subject of competition between mental health/substance abuse and medical/surgical plans. For instance, health plans compete on their formulary designs, both in terms of the drugs that are covered and payment terms with pharmaceutical companies. Moreover, a particular health plan's formulary design is influenced by the outcome of its direct contracts with pharmaceutical manufacturers. Requiring health plans to exchange information and/or reach agreements on these terms may result in reduced competition on formulary design and could reduce the ability to contract competitively with the pharmaceutical industry. Also, these actions may result in the amounts competing health plans pay pharmaceutical companies being reduced below the levels that would prevail in a competitive market, which could adversely affect the provision of pharmaceutical company products. Similarly, health plans compete on the compensation they pay contracting and non-contracting health care providers, including physicians and hospitals, and requiring plans to exchange information and agree on such terms may result in provider compensation being reduced below competitive levels, which could adversely affect the provision of health care services.

In addition to these competitive effects, these actions also may expose health plans attempting to comply with subparagraphs (B)-(D) to the risk of antitrust liability. Agreements between competing purchasers on the amounts they will pay for products or services can be per se illegal under Section 1 of the Sherman Act, and exchanges between competitors of competitively sensitive information regarding such matters can violate Section 1 if such exchanges result in anticompetitive effects. Such exchanges also can be used as evidence of alleged price fixing. See, e.g., *Bellevue Drug. Co. v. Advance PCS,* 2004-Trade Cas. (CCH) ¶ 74,329 (E.D. Pa. 2004) (plaintiff pharmacies adequately alleged per se price fixing claim against pharmacy benefit manager and plan sponsors regarding conspiracy not to bid up prices); *Todd v. Exxon Corp.*, 275 F.3d 191 (2d Cir. 2001) (exchanges between competing employers of salary information can form the basis of a violation of § 1 of the Sherman Act); *United States v. United States Gypsum Co.*, 438 U.S. 432, 443 (1978) ("Exchanges of current price information, of course, have the greatest potential for generating anticompetitive effects and although not per se unlawful have consistently been held to violate the Sherman Act.").

Also problematic is the proposed requirement of parity on standards for admission to provider networks, which will require competing health plans to share information and perhaps reach agreements with respect to the manner in which they compete to develop and offer their provider networks. Such exchanges and agreements may reduce the degree to which health

plans compete regarding who they choose to include in their networks and how they differentiate their networks in marketing them to employers and health plan members. Moreover, if the standards agreed to by competing plans result in certain providers being excluded from both of those plans' networks, the excluded providers could try to challenge this exclusion under the antitrust laws, including by alleging they are the victims of a group boycott. See, e.g., *Welchlin v. Tenet Healthcare Corp.*, 366 F. Supp.2d 338 (D.S.C. 2005) (denying summary judgment against antitrust claim that hospital and doctors violated § 1 of the Sherman Act by excluding osteopathic physicians from medical staff); *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378 (1981) (Blue Cross of Kansas City's refusal to enter into a participation agreement with hospital formed basis of claims under §§ 1 and 2 of the Sherman Act against Blue Cross of Kansas City and the national Blue Cross Association).[1]

As this discussion illustrates, compliance with subparagraphs (B)-(D) of Section 2590.712(c)(4)(ii) may require health plans to engage in activities with serious competitive implications and could expose them to potential antitrust liability. Alternatively, to avoid these risks, medical insurance companies may stop subcontracting with third-party mental health/substance abuse providers even when it may be more efficient for them to do so, and also may refuse to participate in "carve out" situations where the customer prefers to contract with a third-party mental health/substance abuse plan. Ultimately, this would result in consumers being deprived of choices when receiving their mental health/substance abuse benefits – a result directly contrary to the goals of the MHPAEA. Blue Shield, therefore, urges you not to include subparagraphs (B)-(D) in the Final Rules.

* * *

[1] In response to the potential antitrust claims described above, health plans may be able to assert that, to the extent the MHPAEA, as implemented by the Interim Rules, requires them to act in a manner directly contrary to the antitrust laws, the Act constitutes an implied repeal of the antitrust laws. See *Credit Suisse Securities (USA) LLC v. Billing*, 551 U.S. 264 (2007) (implied repeal of the antitrust laws is warranted when 1) there exists regulatory authority under the relevant law to supervise the activity in question, 2) there is evidence that the responsible regulatory entity has exercised that authority, and 3) there is a resulting risk that the law at issue and "antitrust laws, if both applicable, would produce conflicting guidance, requirements, duties, privileges, or standards of conduct."). However, an implied repeal is not a bar to an antitrust claim, but rather is a defense on which a health plan may not prevail until it has expended considerable resources in litigation. Thus, the ability to assert this defense is not an adequate substitute for eliminating the risk of antitrust liability by not including subparagraphs (B)-(D) in the Final Rules.

Please let us know if you would like to discuss these comments further. Also, please note that given the concerns expressed in this letter, Blue Shield is providing a copy of the letter both to the Antitrust Division of the Department of Justice and the Federal Trade Commission so they can provide you with any comments they have regarding these issues.

Sincerely,

Robert E. Bloch /s/RBP

Robert E. Bloch