BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

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May 28, 2009

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: Issues under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

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 issues under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA" or "the Act"). BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to more than 102 million – one in three – Americans.

As key stakeholders affected by the mental health parity regulations, Plans are committed to assisting the Departments in developing reasonable and administrable standards for the provision of mental health and substance use disorder benefits provided to group health plans. BCBSA is filing these comments in response to the Departments' request for information (RFI) as issued in the *Federal Register* on April 28, 2009 and in anticipation of the Interim Final Rule (IFR), which is expected to be issued on or before October 3, 2009, the effective date of the Act. Our comments include specific recommendations as well as requests for clarification on particular areas for regulation.

I. Effective Date

A. ***BCBSA requests the Departments adopt a non-enforcement policy or good faith compliance period for the first plan year for which the Act applies to any particular plan.***

The Act is generally effective for plan years beginning after October 3, 2009. It is our understanding the Departments will issue interim final regulations on or before this date. For many applicable Plans, the Act becomes effective January 1, 2010, the first plan year following October 3, 2009. It is unclear how many provisions of the Act should be interpreted, leaving Plans and sponsors of group health plans unsure of how to implement many of the Act's requirements. Even in the event regulations are issued well before October 3, 2009, Plans would have insufficient time to modify their group health insurance policies in order to comply with the Act's requirements as clarified in the regulations, as well as meet applicable state filing requirements with regard to such policies – including filing the modified policies or riders with multiple states as required.

Accordingly, BCBSA requests, as well as recommends, that the Departments adopt a nonenforcement policy for at least the first plan year following the effective date of the Act to provide relief to group health plan sponsors and Plans, so long as policies and plans are amended in a good faith effort to comply with the Act. The Departments previously adopted such a policy shortly after the first Mental Health Parity Act was passed, and various agencies frequently adopt similar policies.[1] A nonenforcement policy would allow Plans and group health plan sponsors the necessary time to appropriately and adequately address the Act's requirements with the benefit of the Departments' guidance as expressed in the expected regulations, and file amended policies as required under the laws of their states.

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[1] See, e.g., Mental Health Parity; Interim Rules HIPAA Mental Health Parity Act; Proposed Rule, 62 Fed. Reg. 66931, 66956 (Dec. 22, 1997) (under certain circumstances no enforcement action will be taken against group health plans that in good faith attempt to comply with certain section of Act); FTC Enforcement Policy: Identity Theft Red Flags Rule, 16 CFR 681.2, issued Oct. 22, 2008, delaying the implementation of the Red Flag rule from November 1, 2008 to May 1, 2009 to allow covered entities to adopt appropriate programs, available at http://www.ftc.gov/os/2008/10/081022idtheftredflagsrule.pdf. Telemarketing Sales Rule, 69 Fed. Reg. 67287, 67290 (Nov. 14, 2004) (FTC "will forbear from bringing any enforcement action for violation" of the Telemarketing Sales Rule against certain telemarketers pending completion of review of policy); Health Insurance Reform: Modifications to the Electronic Data Transaction Standards and Code Sets, 68 Fed. Reg. 8381, 8384 (Feb. 20, 2003) (reserving authority to "penalize noncompliance" with the standards to those entities that fail to make reasonable efforts to comply during an interim period); Notice and Request for Comments on Annual Reporting Enforcement Policy, 62 Fed. Reg. 11929 (March 13, 1997) (SOP 92–6 guidelines applicable after December 15, 1995, but absent guidance, the Department would not reject annual reports of multiemployer plans filed for the 1996 and 1997 plan years solely for failure to follow SOP 92–6; relief extended to 1998 plan years. See Notice on Annual Reporting Policy, 62 Fed. Reg. 65506 (Nov. 25, 1998)); Technical Release No. 92-01, DOL Enforcement Policy for Welfare Plans with Participant Contributions (May 28, 1992) (announcing limited enforcement policy to provide relief while Department continued to consider issues).

It is well-established that it is within the Departments' collective discretion to promulgate such a nonenforcement policy. There is a general presumption under the Administrative Procedures Act (APA) that actions committed to an agency's discretion, such as an agency determination not to enforce a statute, are not subject to judicial review under the APA. Heckler v. Chaney, 470 U.S. 821, 831 (1985). The temporary nature of the requested nonenforcement policy, along with the nonenforcement policy precedent under the first Mental Health Parity Act, and the practice of many other agencies under similar circumstances, suggests the adoption and publication of a temporary nonenforcement policy is well within the discretion of the Departments.

B. *BCBSA requests clarification that the term "plan year" is defined by the renewal date for any underlying insurance policy when there is no other plan year specified by a group health plan.*

It is possible that plan sponsors will designate in plan documents a plan year that differs from a policy's renewal date. In this case, the plan year designated by the plan sponsor will control. However, in many cases involving insured group health plans, the employer may not have a plan document establishing a plan year for the group health plan. We are requesting regulatory confirmation that the renewal dates for the underlying policies should control where there is no group health plan year (other than the renewal date for the insurance policy) established by the plan sponsor.

We believe this interpretation is consistent with the term "plan year" as it has been interpreted by the Health Care Financing Administration (HCFA) under the Public Health Service Act (PHSA) group market rules (to which the Act was added, along with ERISA and the Code). In 1999, HCFA issued Insurance Standards Bulletin No. 99-03 providing that the COBRA definition of plan year applies for purposes of the Mental Health Parity Act of 1996. More specifically, the definition that HCFA provided for the term plan year (taken from COBRA regulations) is as follows:

The year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

> *(1) The deductible/limit year used under the plan.*
>
> *(2) If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year.*
>
> *(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year.*
>
> *(4) In any other case, the plan year is the calendar year.*

We request clarification that, where there is no group health plan document to the contrary, the group policy will be treated as the applicable plan document and the renewal date of the underlying policy is the controlling plan year for determining the effective date of the Act.

C. *BCBSA requests confirmation that the effective date for multiple employer welfare arrangements (MEWAs) can be determined either on an employer-by-employer basis or by using the renewal date for any insurance policy issued to a Trust under the MEWA in certain cases.*

The Department of Labor (DOL) generally treats each employer participating in a MEWA as having sponsored its own individual plan. Accordingly, we request guidance that the effective date for the Act's parity requirements may be determined on an employer-by-employer (or plan-by-plan) basis. Nevertheless, there are many fully-insured MEWAs where the insurance policy is issued to an association-sponsored trust and the participating employers – often, small employers – do not file a Form 5500 or have a separate group health plan document or contract. In those cases, we request clarification the Act should be effective as of the renewal date for the policy issued to the association-sponsored trust.

D. *BCBSA requests clarification of the effective date for a plan covering both union and non-union employees.*

The Act includes a special rule for collectively bargained plans. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of enactment – October 3, 2008 – the Act shall not apply to plan years beginning before the later of: 1) the date on which the last collective bargaining agreements relating to the plan terminates; or 2) January 1, 2010.

Where a plan covers both collectively bargained and non-collectively bargained employees, we request guidance clarifying whether the extended effective date for collectively bargained plans should be determined based on all facts and circumstances. For example, where a majority of plan participants are union employees, the extended effective date should apply. On the other hand, where only a few plan participants are subject to a collective bargaining agreement, the general effective date should apply to the plan as a whole.

II. Exemptions from the Act

A. *Small Employer Exemption: BCBSA requests guidance that permits the use of a full-time equivalency rule and provides deference to state law rules for purposes of determining the number of employees.*

The Act provides an exemption from the parity requirements for small employers. Under the Act, the term small employer is defined as, with respect to a calendar year and a plan year, an employer who employed an average of at least two (or one in certain states) but not more than 50 employees on business days during the preceding calendar year, subject to the controlled group rules under Section 414 of the Code and using rules under Section 4980D of the Code with regard to employers not in existence during the preceding year and predecessor employers.

In 1999, HCFA issued Insurance Standards Bulletin No. 99-03 providing the term "employee" has the meaning given such term under section 3(6) of ERISA – any individual employed by an employer. The Bulletin goes on to state that once it is determined there is an employer-employee relationship, the question of whether an

employee is full or part-time is irrelevant under the PHSA. In other words, the Bulletin requires, for purposes of the PHSA, that full and part-time employees be counted for purposes of determining whether an employer meets the small employer exemption from the parity requirements. The Bulletin also points out that for purposes of guaranteed availability, a state might have a definition of employee that does not include part-time employees, but that would be preempted for purposes of the parity requirements.

We believe a better approach, in general, is found in the language that was proposed as part of the parity regulations – that language provided a full-time equivalence (FTE) rule. See Prop. DOL Reg. § 2590.732(e). The final regulations, however, did not adopt section (e), reserving the calculation of employees for future guidance. Under the FTE method, the total number of employees may be determined by totaling all employment hours, not to exceed 40, for each full and part-time employee who was not employed full-time during the previous year and dividing the total number by a figure that represents the annual full-time hours under the employer's general employment practices (not to exceed 40 hours) and adding the result to the average number of FTEs employed on business days during the proceeding calendar year. This is an approach similar to that used under COBRA. See Treas. Reg. §54.4980B-2 Q&A-5(e).

We request guidance confirming that one permissible approach for counting employees for purposes of the small employer exemption is a full-time equivalency approach similar to that found in the proposed parity regulations. It would be far too onerous to require small employers to perform one calculation of employees for purposes of determining whether COBRA applies, and a second, different calculation of employees for purposes of determining whether the parity requirements apply.

We are also concerned there are states where different approaches are used for counting employees (e.g., only eligible employees are counted for community rating laws that only apply to small employers). Accordingly, we request guidance that allows plans to use the full-time equivalency rule discussed above or applicable state law defining small groups. It would be inequitable to require an employer that may have 60 employees, but is considered a small group under state law because only 45 employees are eligible, to be subject to small group community rating and then force the same plan to comply with the parity requirements, which are likely to be quite costly.

B. *Cost Exemption: BCBSA requests guidance permitting projected actuarial determinations of total costs for plan years after a plan has first met the cost exemption.*

If the application of the Act with regard to a particular group health plan results, after six months, in an increase for the plan year of the actual total cost of coverage – including medical/surgical benefits and mental health/substance use disorder benefits – of two percent in the first plan year and one percent in subsequent plan years, then the Plan is exempt from the parity requirements under the Act for one year (the second plan year).

One possible interpretation of the Act would be to require Plans with an increase in total cost in excess of two percent in the first plan year to again comply with parity requirements under the Act in the third year, exempting the Plan from the parity requirements for only the second plan year. If the increase in total cost of coverage attributable to the application of the parity requirements is more than one percent in the first six months of the plan year, then the Plan would again be exempt from the parity

requirements of the Act during the fourth plan year, but would have to comply with the parity requirements once again in the fifth plan year, and so on.

It would be extraordinarily difficult 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 with the Act's parity requirements. A more likely scenario for an employer in this situation would be to comply with the Act's parity requirements in the first plan year, make the determination that the increase in total cost is in excess of two percent, and take advantage of the cost exemption from parity in the second plan year. Then, the employer would amend the group health plan to eliminate all mental health and substance use disorder benefits in the third plan year, as permitted under the Act, rather than repeat the process to meet the cost exemption every other year.

We request guidance that provides that, once the cost exemption is met 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 the employer would terminate all mental health and substance use disorder benefits) and would likely confuse participants as to whether or how the parity requirements would apply for a particular plan year. In addition, we request guidance clarifying that "cost" includes not only claims experience (including prescription drug claims), but also administrative costs associated with complying with the parity requirements.

III. Definitions of a Mental Health or Substance Use Disorder Benefit; Disclosures Regarding Medical Necessity Determinations

A. *BCBSA requests guidance confirming a group health plan has the flexibility to define conditions as medical, mental health, or substance use disorders, so long as the classification is based upon the standard practice of medicine or evidence-based treatment guidelines.*

We are requesting the regulations confirm that the definition of a mental health or substance use disorder be left to the Plan, except to the extent that a state or federal law requires otherwise. Early versions of the Act would have required Plans to use the DSM-IV to define mental health and substance use disorders. Congress, however, did not include such a requirement in the version of the Act that was passed into law. The Act passed into law provides that mental health and substance use disorder benefits are defined as benefits with respect to services for mental health or substance use disorder conditions (as applicable) as defined under the terms of the plan and in accordance with applicable federal and state law. See ERISA §712(e)(4) & (5).

Accordingly, the regulations should reflect that Plans are not forced to adopt a uniform definition of disorders and have the flexibility to classify disorders as either medical or mental health conditions or substance use disorders in their own plan document, so long as there is scientific or medical support for the classification and the classifications are not designed to circumvent the parity requirements (e.g., by classifying a condition that is clearly a mental health condition, such as depression, as a medical condition). For example, many Plans treat jet lag syndrome or caffeine addiction as medical conditions, subject to plan rules regarding medical benefits, even though these conditions may appear in the DSM-IV. Whether such conditions are medical or mental health should be

left to employer plan sponsors or Plans to determine based on standard practice of medicine or evidence-based treatment guidelines.

B. ***BCBSA requests guidance confirming that a group health plan has the ability to exclude certain conditions and certain treatments, treatment settings, or providers from the definition of mental health or substance use disorder benefits under the plan.***

Mental health and substance use disorder benefits are defined as benefits with respect to services for treatment of mental health or substance use disorder conditions (as applicable) as defined under the terms of the plan and in accordance with applicable federal and state law. See ERISA § 712(e)(4) & (5). Based on this language, we are requesting guidance confirming that Plans are permitted to not only exclude coverage for a particular mental health condition or substance use disorder, but also exclude coverage for a particular inpatient or outpatient treatment, treatment setting, or provider for a mental health condition or substance use disorder that is otherwise covered because the treatment, setting, or provider is investigational, experimental, or is not in keeping with acceptable medical practice. An example of a commonly excluded treatment would be vagal nerve stimulation, which is an unproven treatment for depression – and is not even covered by Medicare.

Based on the language of the statute and as explained above, we believe it is clear that exclusions of particular mental health conditions or substance use disorders should be permitted. For example, it is permissible to exclude treatment for learning disorders altogether unless otherwise required by state law. It should also be permissible for group health plans to exclude certain treatments (e.g., certain educational programs) and treatment facilities (e.g., "halfway houses") because the Act gives insurers and employer plan sponsors the flexibility to define what mental health/substance use disorder services are covered under the ERISA plan/group policy. As long as there are meaningful evidence-based treatments available for a particular mental health condition or substance use disorder, Plans should be permitted to exclude certain treatments or settings with respect to mental health conditions or substance use disorders. This would be consistent with typical provisions for medical/surgical coverage where a medical/surgical condition is generally covered, but certain treatments, settings, or providers are excluded. Additionally, Plans should be permitted to have blanket exclusions for treatments, settings, or providers that are investigational, experimental, or generally not accepted medical practice or settings.

C. BCBSA requests guidance providing that the rules set forth in the claims procedure regulations should be relied upon as the rules for providing information upon the denial of mental health benefits.

Under the Act, group health plans and insurers must provide certain information upon the denial of mental health benefits, in accordance with regulations. The Act states:

> The reason for any denial under the plan (or coverage) or reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in

accordance with regulations. 26 U.S.C. §9812(a)(4), 29 U.S.C. §1185a(a)(4) and 42 U.S.C. §300gg-51(a)(4).

Group health plans are already subject to extensive claims procedure regulations that set forth rules regarding adverse benefit determinations -- including decisions based on medical necessity – requiring that any internal protocol or guideline relied upon in making the decision be disclosed. 29 C.F.R. §2560.503-1. It would be unnecessarily duplicative to create a new set of rules for providing information with regard to the denial of mental health benefits – instead, we are requesting that the regulations defer to the existing claims procedure regulations for purposes of denials of mental health benefits.

IV. Guidance Requested on How Parity is Determined

The Act prohibits group health plans that provide medical and surgical benefits and mental health or substance use disorder benefits from applying financial requirements or treatment limits that are more restrictive than the predominant financial requirement or treatment limit that applies to substantially all medical and surgical benefits. ERISA § 712(a)(3)(A). Under this rule, for a limit to be applied to mental health or substance use disorder benefits, it must first apply to substantially all medical and surgical benefits, and then it must be the predominant limit that applies.

The Act defines financial requirements to include deductibles, co-payments, coinsurance, and out-of-pocket expenses. The Act defines treatment limitations to include limits on the frequency of visits, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. The Act defines the term predominant as the most common or frequent of such type of limit or requirement. ERISA § 712(a)(3)(B). The Act does not include a definition of when a financial requirement or treatment limit applies to substantially all medical and surgical benefits.

A. *BCBSA requests clarification of when financial requirements and treatment limitations would apply to substantially all medical and surgical benefits for purposes of determining parity with the mental health/substance use disorder benefits under a plan.*

The Act does not define the term “substantially all.” Notably, the 1996 Mental Health Parity Act used this term with respect to annual and lifetime limits, which was interpreted in subsequent regulations. Those regulations provide useful guidelines, but make more sense in the context of requiring parity in annual or lifetime limits. We request the guidance retain those guidelines for annual or lifetime limits, but clarify the meaning of “substantially all” for purposes of financial requirements and treatment limits. We believe a similar method (i.e., one that focuses on the dollar amount or costs based on actual claims experience or reasonable actuarial estimates) should be used to determine if a treatment limit or financial requirement applies to substantially all medical and surgical benefits.

B. *BCBSA requests guidance clarifying that treatment limits and financial requirements for mental health/substance use disorder benefits should be in parity with medical/surgical benefits based on a side-by-side comparison.*

The Act requires the treatment limits and financial requirements that apply to mental health and substance use disorder benefits be no more restrictive than the predominant

limitation applied to substantially all medical and surgical benefits covered under the plan. A reasonable interpretation of this language is to analyze limits based on same categories of services that are generally available for treatment of medical/surgical conditions as well as mental health and substance use disorder conditions. In other words, for parity purposes, a Plan should be permitted to compare: 1) inpatient days for medical and surgical benefits with inpatient days for mental health and substance use disorders; 2) outpatient visit limits for medical and surgical benefits with outpatient visit limits for mental health visits and substance use disorder benefits; 3) physical therapy coverage for medical and surgical benefits with physical therapy coverage for mental health or substance use disorder benefits; and so on. Additionally, we request the guidance provide flexibility to plan sponsors and Plans to determine the categories of services for parity purposes.

Adopting this interpretive approach ensures parity between treatment categories. To read the Act to permit the application of only those limits that apply to substantially all of a plan's medical and surgical benefits without regard for similar categories of services (e.g., inpatient hospital) would essentially prohibit the application of most limits to mental health or substance use disorder benefits – thereby resulting in the disparate treatment of medical and surgical and mental health benefits. The Act was intended to provide parity for mental health and substance use disorder benefits, not preferential treatment.

C. *BCBSA requests guidance confirming the Act permits differences in medical management tools for mental health/substance use disorder benefits.*

The Act explicitly requires parity for treatment limits and financial requirements as well as for out-of-network coverage. There is no express provision requiring parity for medical management techniques. In our view, had Congress wanted to mandate parity in medical management, it would have imposed a similar explicit parity requirement. Nevertheless, we request guidance confirming the Act permits differences in medical management tools for mental health/substance use disorder benefits.

We believe our conclusion, based on the statute's construction stated above, is supported by the fact the Act includes a rule of construction that states "nothing shall be construed as affecting the terms and conditions of the plan or coverage to the extent that the plan terms and conditions do not conflict with the new parity requirements." We believe the rule of construction continues to protect medical management tools, including medical necessity provisions, so long as those provisions are not in conflict with the parity requirements. Finally, we note the Act requires Plans to disclose, upon request or as otherwise required by law, criteria used to make medical necessity determinations and the reasons for any denial of reimbursement for services. This provision indicates that Congress was aware of medical management provisions, and rather than imposing a parity mandate, imposed a disclosure requirement for such provisions. ERISA § 712 (a)(4).

In addition, we request guidance that Plans are permitted to utilize the normal and customary consequences for failing to meet medical management techniques. For example, a typical consequence of failing to obtain preauthorization is that a particular treatment is not covered (unless there was a bona fide emergency where prior authorization was not reasonable) or the participant may be charged an additional amount for the procedure that was not preauthorized. These penalties should not be considered to be financial requirements or treatment limits subject to the parity

requirements, but are instead an integral part of the medical management tools permitted by the Act.

D. *BCBSA requests guidance confirming that separate but equal deductibles are permitted under the Act.*

This issue involves the application of the financial requirements parity provision, which provides the following:

> The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. ERISA § 712(a)(1)(A)(i) (emphasis added).

The underscored language above has created some uncertainty regarding the ability of Plans to impose separate but otherwise equal deductibles for medical and mental health benefits (e.g., each is subject to a $1,000 annual deductible).

We believe Plans should be able to impose separate but equal deductibles for medical/surgical and mental health/substance use disorder benefits for a number of reasons. Importantly, the Act specifically defines the term "financial requirements" to include deductibles and out of pocket expenses. ERISA § 712(a)(3)(B)(i). In other words, the Act mandates parity between the deductibles that apply to medical benefits and the deductibles that apply to mental health benefits – if separate deductibles were not permitted, the requirement in the statute explicitly mandating parity in deductibles would have no meaning.

Accordingly, we believe the parity requirement contemplates that a Plan can apply separate deductibles to mental health or substance use disorder benefits from the deductibles applied to medical/surgical benefits, provided the deductibles are no more restrictive than the deductibles applied to substantially all medical surgical benefits covered by the plan.

Also, focusing on the word "only" in the final clause leads us to believe this language is intended either to prohibit a Plan from imposing: 1) a deductible for mental health or substance use disorder benefits if the Plan does not impose a deductible for medical and surgical benefits; or 2) an additional deductible requirement only for mental health or substance use disorder benefits.

From a practical perspective, this interpretation is necessary because there are many group health plans that offer mental health benefits through a separate service provider, but still under the same group policy. Nevertheless, the recordkeeping systems are not coordinated and it is therefore impossible to track the mental health deductible as part of the overall medical deductible.

Accordingly, we request guidance clarifying that group health plans are able to impose separate but equal deductibles for medical/surgical and mental health/substance use

disorder benefits, but not different or additional deductibles for mental health/substance use disorder benefits.

E. *BCBSA requests guidance that age-based limits are not considered treatment limits under the Act.*

The Act prohibits group health plans that provide medical and surgical benefits and mental health and substance use disorder benefits from applying treatment limits that are more restrictive than the predominant financial requirement or treatment limit that applies to substantially all medical and surgical benefits. ERISA § 712(a)(3)(A). The Act defines treatment limitations to include limits on the frequency of visits, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

Some Plans limit coverage for certain developmental disorders that are classified as mental health conditions based on age. For example, treatment for a particular disorder may not be covered under the plan after a certain age (e.g., age 21). Typically, such age-based limits are based on scientific or medical evidence that treatment after a particular age would not be effective. When coverage is offered before the age limit is met, the number of days and visits could be unlimited (and/or in parity) until the age limit is met. Certain medical/surgical benefits may also be subject to limits that are similar and effectively age-based (e.g., pediatric care is offered only until a child reaches age 18), which also reflects generally accepted medical practice and science.

We are requesting guidance that eliminating coverage at a certain age is not considered a limit on the scope or duration of treatment for purposes of applying the parity requirements to the treatment limits under a plan.

F. *BCBSA requests guidance that it is permissible for a Plan to charge a specialist copay for all mental health service providers, where a primary care physician (subject to a general copay) is available under the Plan to refer patients to the mental health specialists based on an initial evaluation and diagnosis and treatment of a mental health condition or substance use disorder.*

A common plan design involves establishing lower copayments for patients who seek care from a primary care provider (e.g., internal medicine, family practitioner, pediatrician) and higher copayments for patients that seek care from specialists. As a general matter, primary care physicians are often the primary providers of mental health services to patients, evaluating, diagnosing, and treating many common mental health conditions including depression and attention deficit disorder. When the primary care provider has insufficient expertise to effectively diagnose and/or treat the medical or mental health condition, they refer the patient to a specialist. Under these circumstances, we believe group health plans should be permitted to classify all mental health providers as specialists and apply the plan's specialist co-pay to all such providers, so long as any specialist co-pay assigned to mental health providers is no more restrictive than the co-pays applied to substantially all medical/surgical surgical specialists under the plan.

IV. Application of State Law Mandates

BCBSA requests guidance confirming the Act does not preempt any dollar, day, or visit limitations – or any other annual or lifetime limit, financial requirement, or treatment limitations – on state mandates requiring mental health and substance use disorder benefits.

Both the 1996 and 2008 Acts are subject to the preemption provision of section 731 of ERISA and section 2723 of the PHSA, both of which preempt state insurance laws only to the extent they would prevent the application of the federal parity standards. Under this rule, states are generally free to implement more stringent insurance laws, including mental health benefit mandates or more extensive parity requirements. Pursuant to this flexibility, states have implemented a wide variety of mental health benefit and substance use disorder mandates, but often have limited the cost of those mandates by imposing dollar limits or day or visit limitations. Notably, the conference report accompanying HIPAA indicates that HIPAA's preemption is intended to be the narrowest preemption of state laws.

We are requesting guidance confirming the Act does not preempt any dollar, day, or visit limitations, or any annual or lifetime limits, on state mandates requiring mental health and substance use disorder benefits. Those limitations were specifically imposed as part of the state political process and were intended to limit the burden on insurers, employers, and individuals who would have to pay increased premiums for open-ended coverage. If those limits are preempted, the federal government will have effectively forced employers to comply with unlimited state mandates which was never the intent of the states. Moreover, employers are not required under the Act to offer mental health or substance use disorder benefits at all. To require the application of a state law that was never intended to require mental health and substance use benefits beyond a certain period of time or dollar limit would encourage employers to eliminate mental health and substance use benefits altogether.

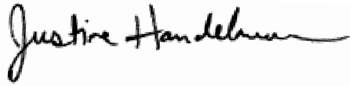
We believe the Departments can and should adopt our suggested recommendation. First, the Departments could conclude that respecting such state law limits merely allows the state to impose a limited mandate, rather than a benefit with impermissible annual limits or treatment limits. States should not be forced to rewrite their laws to adopt an alternative mandate structure with other types of limits (e.g., on specific treatments, covered conditions, etc.). Second, the Departments could conclude that if the Act did preempt any limits permitted under state law, preempting that one piece of the law would so upset the policy balance intended by the state legislature such that the entire mandate would be preempted. See generally Norman Singer, Statutes and Statutory Construction v.2, 44:1-44:19 (West Group 7th ed.) (2001) (discussing severability and preemption).

* * *

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 at kris.haltmeyer@bcbsa.com.

Sincerely,



Justine Handelman
Executive Director
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