



May 27, 2022

Erica Weyhenmeyer
Chair, Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Damion Hughes
Chair, Market Conduct Examination Guidelines (D) Working Group

Submitted electronically to: Petra Wallace (pwallace@naic.org)

Dear Ms. Weyhenmeyer and Mr. Hughes,

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the proposed update to chapter 24B of the 2022 Market Regulation Handbook, *Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination* (Handbook).

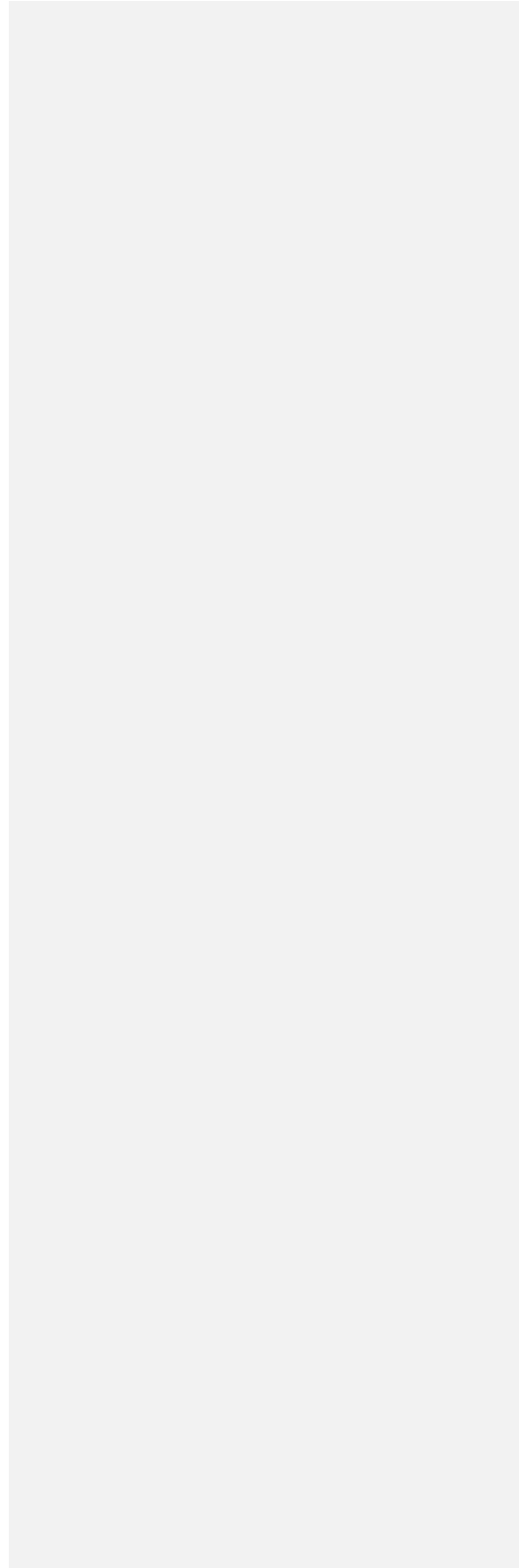
BCBSA is a national federation of 34 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide health care coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA and BCBS companies are committed to robust access to quality mental health and substance use disorder services (MH/SUD) for members and want to continue to work with policymakers to improve the ability of regulators, payers and employers to meet the aims of MHPAEA and promote compliance with the requirements. Since the passage of MHPAEA, BCBS companies have actively worked to support the legislation and comply with its requirements. Concurrently, BCBS companies have made strides in addressing broader issues that limit access to care through efforts to fill the gaps created by workforce shortages and support for the integration of physical and behavioral health care.

We recognize there is room for improvement in mental health parity compliance. However, health plans that are working in good faith to comply with the requirements continue to struggle to understand the expectations of regulators on certain facets of MHPAEA compliance, specifically what constitutes compliance for parity between medical/surgical (M/S) benefits and MH/SUD benefits for non-quantitative treatment limits (NQTLs). As such, we appreciate NAIC's efforts to work towards greater clarity in MHPAEA compliance through this update to the Handbook. With consistent and transparent guidance, health plans will be better able to ensure compliance with existing laws and continue to enhance access to care for members.

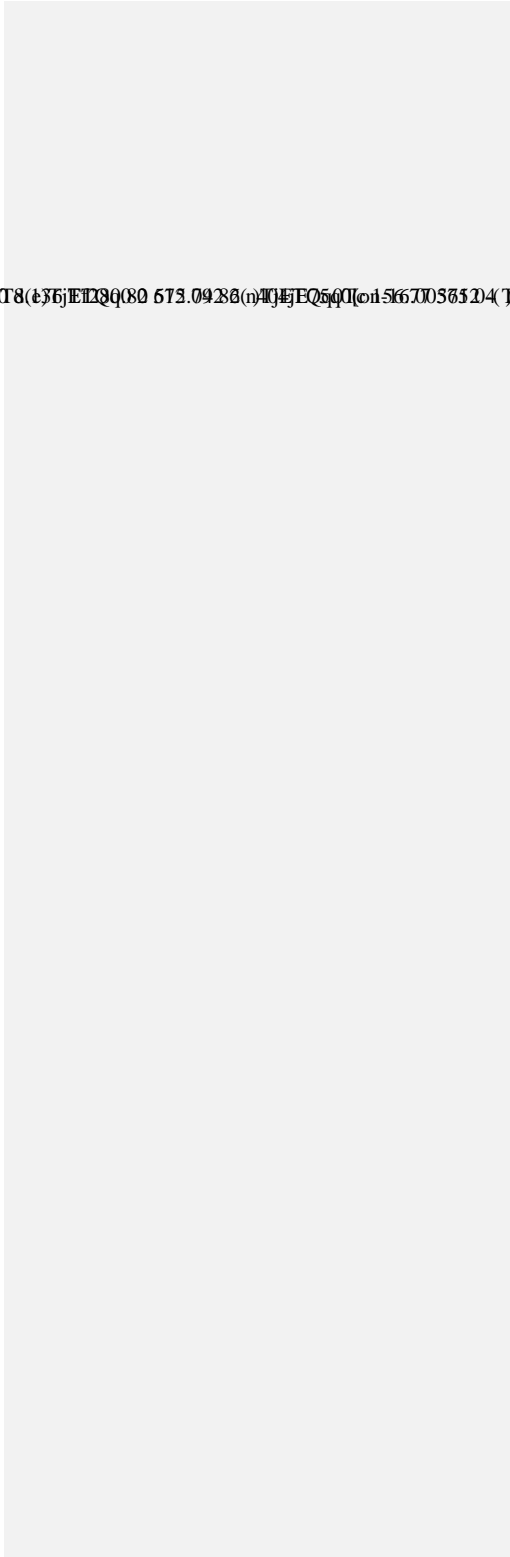
However, we have some concerns about the quantity of information to be submitted for compliance that is proposed in the updates, among a few other technical issues. We have outlined questions and recommended edits in the draft MHPAEA chapter of the Handbook below. Our recommendations focus on:

Aligning the Market Regulation Handbook guidance



with applicable Federal and State law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines) (45 CFR § 146.136(a)).

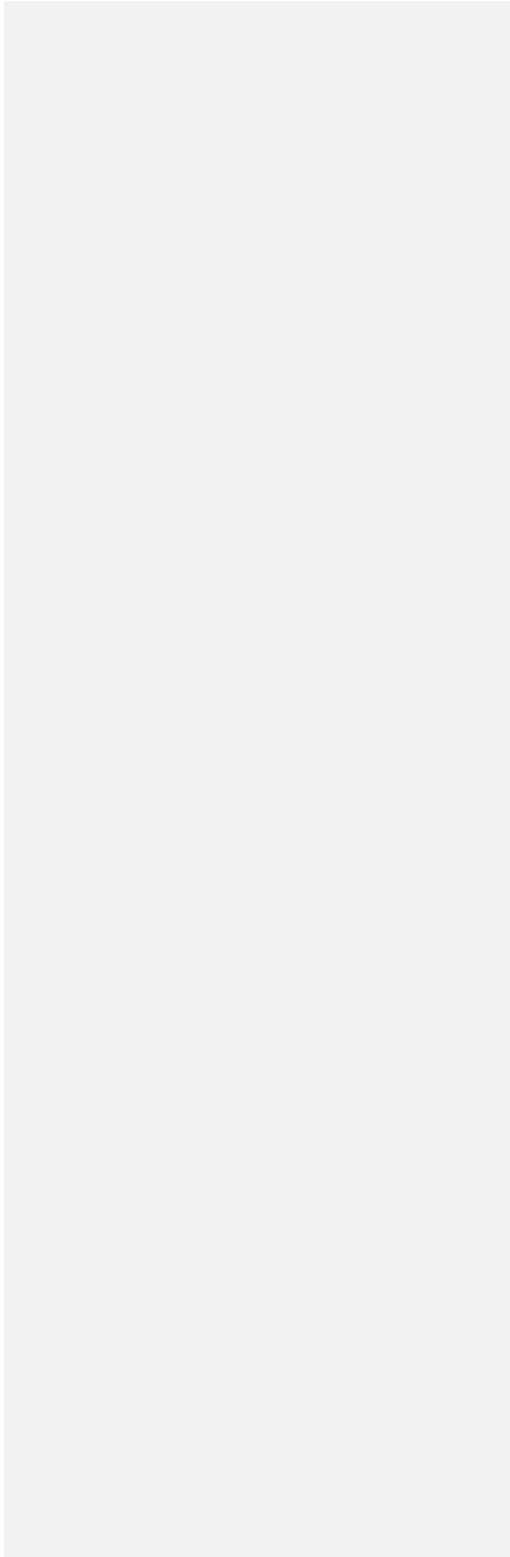
Mental Health Benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines) (45 CFR § 146.136(a)).



Stand

Standard 1

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[U.S. Department of Labor Frequently Asked Questions Guidance: https://www.dol.gov/agencies/ebsa/laws-and-regulations/la](https://www.dol.gov/agencies/ebsa/laws-and-regulations/la)

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 2

The health carrier must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits in determining the classification in which a particular benefit belongs (or applicable sub-classification) (45 CFR § 146.136(c)(2)(ii)(A)).

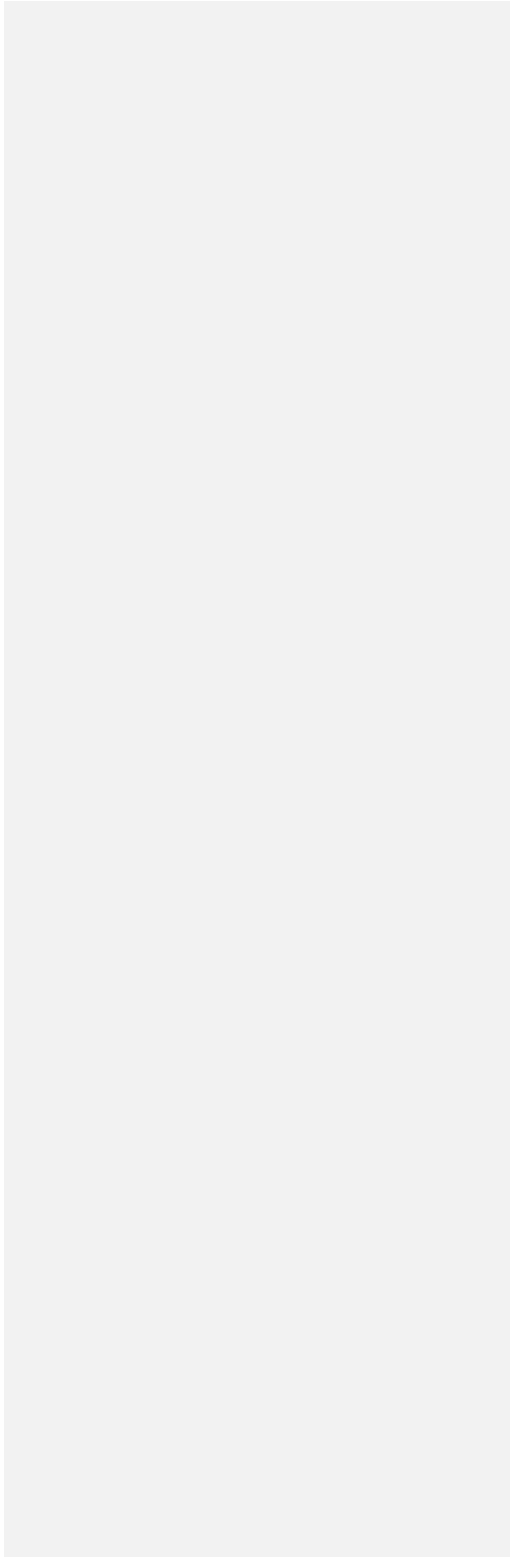


[U.S. Department of Labor Frequently Asked Questions Guidance: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity)

Review Procedures and Criteria

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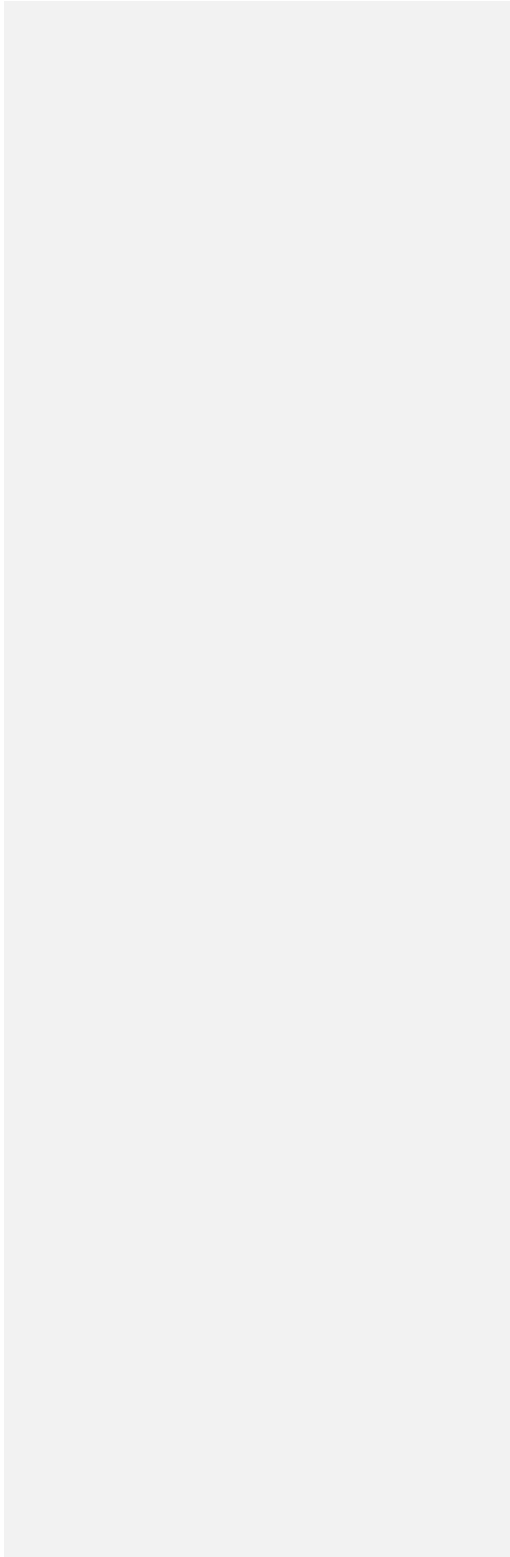
Standards for
Mental Health Services

Standard 4



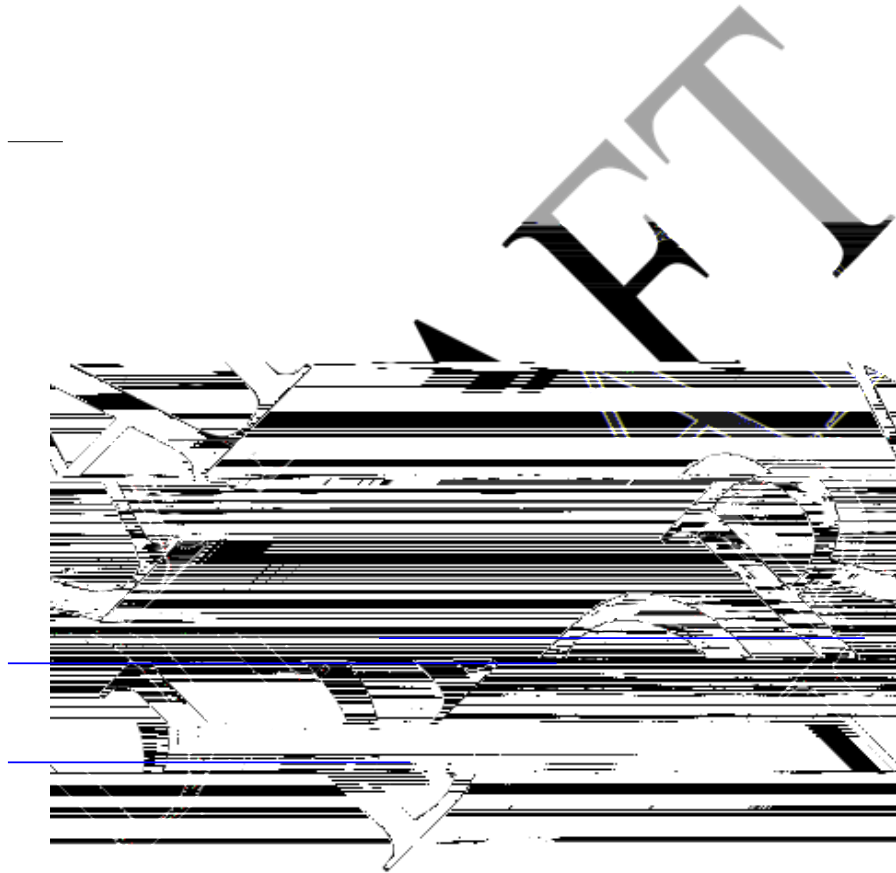
Review Procedures and Criteria

QTLs include annual, episode, and lifetime day and visit limits. (45 CFR § 146.136(c)(1)(ii)). A QTL is considered to apply to substantially all medical/surgical benefits in a



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- ___ Standards for determining provider reimbursement rates
- ___ Samples of provider/facility contracts in use during the exam period



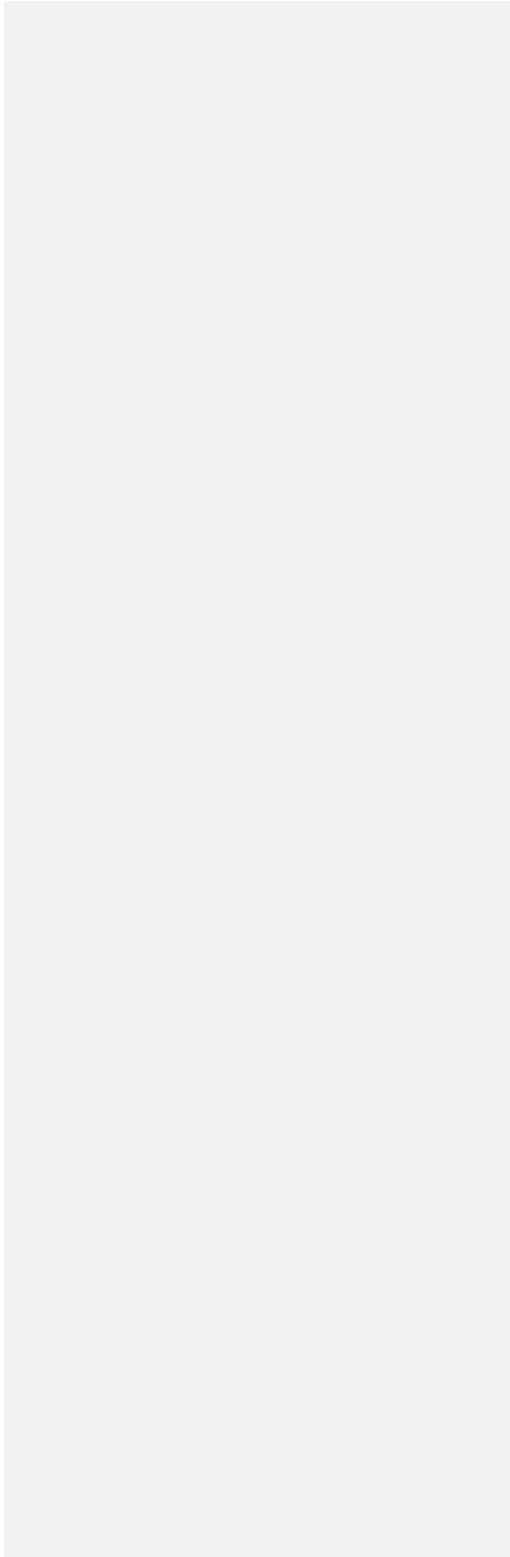
The factors used to determine the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits.

The evidentiary standards for the factors identified, when applicable, provided that every factor shall be defined, and any other evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits, medical or surgical benefits;

The comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are compared and applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification; and

The specific findings

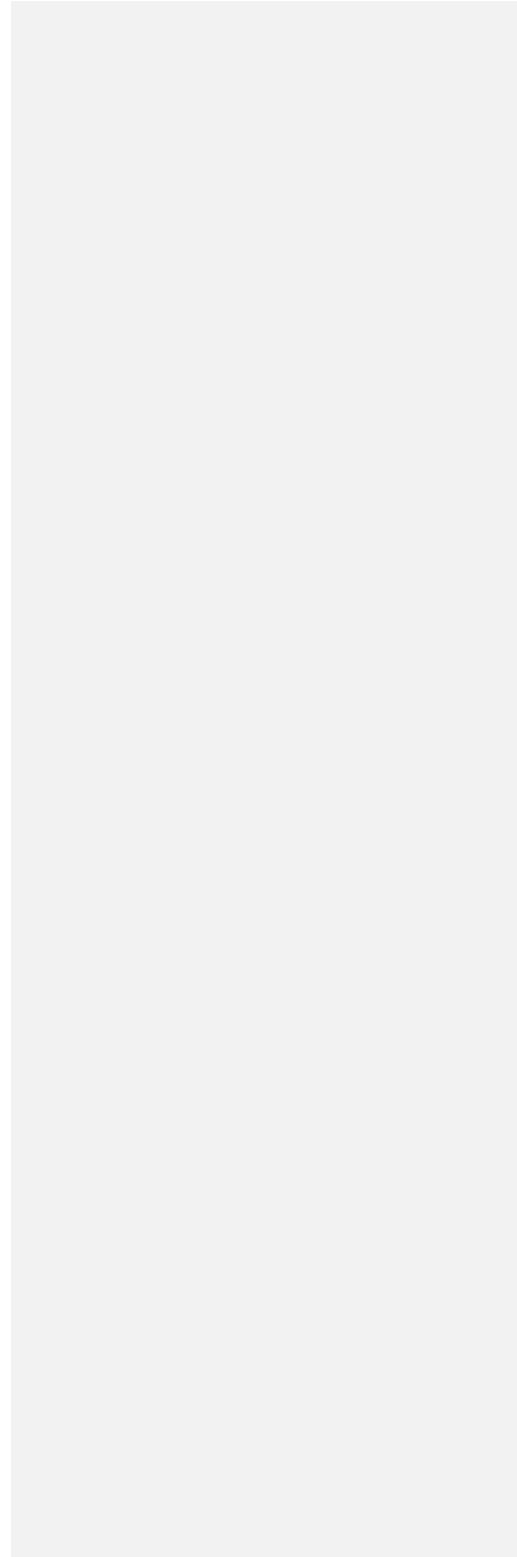
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5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; and
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.





The health carrier shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits (45 CFR § 146.136(d)(2)).

Standards for

Standard 7

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