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Request for Information for Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: IRS-2009-0008-0119
Regulations Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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Submitter Information

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General Comment

See attached file(s)

Attachments

IRS-2009-0008-0154.1: Comment on FR Doc # N/A

National Association of Health Underwriters

America's Benefits Specialists

May 3, 2010

Via electronic transmission

U.S. Department of Labor
Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance
Attention: MHPAEA Comments
Room N-5653
200 Constitution Avenue, NW
Washington, DC 20210

U. S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-4137-NC
P. O. Box 8017
Baltimore, MD 21244-8010

U. S. Department of the Treasury
Internal Revenue Service
Attention: CC:PA:LPD:PR (REG-120692-09)
Room 5205
P. O. Box 7604
Ben Franklin Station
Washington, DC 20044

Dear Sir or Madam:

I am writing in on behalf of The National Association of Health Underwriters (NAHU), a professional trade association representing more than 100,000 health insurance agents, brokers and employee benefit specialists from all across America, in response to the Interim Final Rules (IFR) released by the Departments of Health and Human Services, Labor, and the Treasury on February 2, 2010 (75 Fed. Reg. 5410). The IFR implements the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Division C of Pub. L. No. 110-343).

Background

NAHU has been actively involved in the quest to develop reasonable federal mental health parity protections for American health insurance consumers for many years. Our association, along with many

other employer, insurer and mental health advocacy groups worked with Members of Congress over many months to develop language in the MHPAEA that struck a fair balance between employee access to mental health and substance abuse services and employer flexibility to manage the benefit. We were satisfied at the end of the process that the legislation would meet the objective of all sides to improve access to mental health and substance abuse services in a way that would be cost-effective for our nation's employers. Unfortunately, we are concerned that the IFR goes beyond the legislative intent of the MHPAEA and creates too much of a cost and administrative burden on employers. The rule constructs a new non-quantitative methodology that does not exist today and was not contemplated by the statute. It also includes single deductible, inclusion of pharmacy benefits and a "substantially all" requirement which were not contemplated in the negotiations. The potential impact of these requirements is that employers could drop the mental health and substance abuse benefits all together, or reduce medical/surgical benefits in order to comply with the regulation as currently structured.

We are further concerned that your respective agencies bypassed the Notice of Proposed Rule-Making (NPRM) process and moved directly creating the IFR without conducting cost studies to reasonable financial impact on employers and employees.

The preamble also of the IFR also invited comments on the f scope of services covered by the IFR. We wish to address the following issues:

Single Deductible

The single deductible required by the IFR will make it more difficult for employers and insurers to administer carve out managed care services. During the legislative process a significant amount of time was spent on the issue of medical management, and there is no requirement for a single deductible in the statute. Medical management, at its core, is what makes parity work without increasing costs for employers, and the single deductible requirement will impede medical management significantly. The pharmacy benefit requirement for example, must be applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or mental health or substance use disorder benefits. This factor will be particularly challenging in the case of drugs prescribed solely for the treatment of mental health or substance abuse disorders. We know that primary care physicians frequently prescribe medications for depression for example, and we are concerned that having the drug on the formulary will trigger a requirement for parity in all categories. The end result may be that the employer removes such drugs from the formulary, which will only hurt employee access to care. We strongly believe that separate co-pays and deductible should be allowed. Creating a single deductible will likely mean that the patient will incur greater out of pocket expense at the outset of treatment to satisfy a single deductible for medical/surgical AND mental health/substance abuse services and could result in a delay of treatment. Instead, we feel the current structure of separate financial requirements should be maintained. This will make it easier to use carve out arrangements and will maintain efficiencies in delivery and administrative costs.

For employers who offer multiple plan offerings that include different cost-sharing arrangements, the parity requirement in the regulation stipulates that the mental health and substance abuse benefits be tied to the most generous of the plans being offered or to each plan individually. However, tying to the most generous plan would create unequal benefit structures with respect to plans with less generous medical/surgical

benefits and more generous mental health and substance abuse benefits. These plan designs are inherently different (PPO, HMO, POS) so someone with greater need of mental health services will chose the least expensive option knowing that the benefit will be tied to most expensive menu plan option. Administratively, to consider the mental health carve out tied to each individual plan will be onerous and employers will likely reduce their plan offerings. This will drive up employer cost, reduce employee options and not achieve the balance lawmakers sought in crafting parity.

Non-quantitative Methodology Requirement

It is unclear how employers and insurers will satisfy this requirement. Medical management tools such as "fail-first" and "step" therapies, and coverage exclusions based on the failure of a patient to comply with a treatment plan recommended by a treating health care providers are clearly allowed in the statute, but the regulation for a non-quantitative requirement for prescription drug formulary design, provider network standards and reimbursement rates makes the use of these tools questionable. At best, it will be difficult to administer and adds unnecessary complexity and burden on employers and insurers. We recommend removal of the non-quantitative methodology requirement from the IFR.

Scope of Services

We believe the MHPAEA is clear in that it does not govern decisions made by a group plan with respect to the types of mental health or substance use disorder services or treatment that must be covered.

The legislation states that, except for the parity requirements, nothing in the Act is intended to affect "the terms and conditions of the plan or coverage relating to such benefits" (26 U.S.C. 9812(b), 29 U.S.C. §1185a(b), and 42 U.S.C. §300gg-5(b)). The MHPAEA provisions indicate Congressional intent that group health plans and group health insurers may determine what conditions, treatments, services, or settings of care are covered under the terms and conditions of the plan or insurance policy.

Substantially All Requirements

Under this requirement in the IFR, a plan is prohibited from imposing a type of financial requirement on mental health/substance use disorder benefits if such financial requirement does not apply to "substantially all" medical surgical benefits in the relevant classification. Types of financial requirements cannot be combined and "substantially all" is defined as applying to at least 2/3 of all medical/surgical benefits in the classification.

This is problematic for health plan design because different services are subject to different financial requirements, either copays, coinsurance or both and are unlikely, therefore, to meet the 2/3 requirement for substantially all. In order to comply, the plan would have to waive the financial requirement or adjust medical/surgical financial requirements (which may be incentivizing better health behavior) in order to meet the substantially all requirement. This unintended consequence of the regulation was not the intent of the law. Without flexibility in the categories and subcategories, an unequal balance is likely.

Implementation

Employers and insurers are dealing with numerous new requirements under the recently enacted Patient Protection and Affordable Care Act (PPACA). The many PPACA benefit requirements (which are still being developed and clarified through their own regulatory processes) will have to be calibrated with the regulatory requirements in the IFR. To minimize employer and employee confusion, and allow for sufficient time to merge all of requirements on employers and insurers in a cost-effective way, we suggest extending the effective date of the IFR by one year, July 1, 2011 in order to work clarify the scope and implementation of the rule.

NAHU sincerely appreciates this opportunity to provide comments. We look forward to working with you as implementation of MHPAEA moves forward. If we can be of further assistance, please feel free to call me at (703) 276-3806, or jtrautwein@nahu.org.

Sincerely,

Janet Trautwein, Executive Vice President and CEO

National Association of Health Underwriters