U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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November 27, 2013

The Honorable Tom Harkin
Chairman
The Honorable Lamar Alexander
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

Subject: *Department of the Treasury, Internal Revenue Service; Department of Labor, Employee Benefits Security Administration; and Department of Health and Human Services: Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program*

Pursuant to section 801(a)(2)(A) of title 5, United States Code, this is our report on major rules promulgated by the Department of the Treasury, Internal Revenue Service; Department of Labor, Employee Benefits Security Administration; and Department of Health and Human Services (HHS) (collectively, the agencies) entitled "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program" (RINs: 1545-BI70; 1210-AB30; 0938-AP65). We received the rules on November 13, 2013. The rules were published in the *Federal Register* as final rules on November 13, 2013. 78 Fed. Reg. 68,240.

On April 28, 2009, the agencies published in the *Federal Register* (74 Fed. Reg. 19,155) a request for information (RFI) soliciting comments on the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). On February 2, 2010, after consideration of the comments received in response to the RFI, the agencies published in the *Federal Register* (75 Fed. Reg. 5410) comprehensive interim final regulations implementing MHPAEA. The interim final regulations generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. In light of the comments and other feedback received in response to the interim final regulations, the agencies issued clarifications in several rounds of Frequently Asked Questions. After consideration of the comments and other feedback received from stakeholders, the agencies published these final rules.

The final rules implement MHPAEA, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage. The final rules also contain a technical amendment relating to external review with respect to the multi-state plan program administered by the Office of Personnel Management. The final rules are effective on January 13, 2014, except that the technical amendment relating to external review is effective on December 13, 2013.

Enclosed is our assessment of the agencies' compliance with the procedural steps required by section 801(a)(1)(B)(i) through (iv) of title 5 with respect to the rule. Our review of the procedural steps taken indicates that the agencies complied with the applicable requirements.

If you have any questions about this report or wish to contact GAO officials responsible for the evaluation work relating to the subject matter of the rule, please contact Shirley A. Jones, Assistant General Counsel, at (202) 512-8156.

signed

Robert J. Cramer
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Enclosure

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Chief, Publications and Regulations
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REPORT UNDER 5 U.S.C. § 801(a)(2)(A) ON A MAJOR RULE
ISSUED BY THE
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE,
DEPARTMENT OF LABOR,
EMPLOYEE BENEFITS SECURITY ADMINISTRATION, AND
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ENTITLED
"FINAL RULES UNDER THE PAUL WELLSTONE AND PETE DOMENICI
MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008;
TECHNICAL AMENDMENT TO EXTERNAL REVIEW FOR
MULTI-STATE PLAN PROGRAM"
(RINs: 1545-BI70; 1210-AB30; 0938-AP65)

(i) Cost-benefit analysis

The agencies analyzed the costs and benefits of the rule. According to the agencies, the costs include costs associated with increased utilization of mental health and substance use disorder benefits and costs associated with cumulative financial requirements and quantitative treatment limitations, including deductibles. Additionally, the agencies include compliance review costs and costs associated with Mental Health Parity and Addiction Equity Act (MHPAEA) disclosures. The agencies believe that the benefits of the rule justify its costs. The agencies expect that MHPAEA and these final regulations will have their greatest impact on people needing the most intensive treatment and financial protection. The agencies cannot estimate how large this impact will be, but the numbers of beneficiaries who have a medical necessity for substantial amount of care are likely to be relatively small. In general, however, the agencies state that improvements in coverage of mental health and substance use disorder services expected to result from implementation of MHPAEA can be expected to reduce some of the financial risk (such as bankruptcies) and also yield successful treatment for people with mental health or substance use disorder problems. Earlier entry into treatment may have a salutary impact on entry into disability programs. Improving coverage of mental health and substance use disorder treatment could also more generally improve productivity and improve earnings among those with these conditions.

The agencies included a table summarizing the costs associated with the final regulations above the costs that were previously estimated for the interim final regulations. Over a 5-year period of 2014 to 2018, the total undiscounted cost of the rule is estimated to be $1.16 billion in 2012 dollars. The table also displays the costs discounted at 3 percent and 7 percent and includes a transfer of $3.5 billion over the 5-year period.

(ii) Agency actions relevant to the Regulatory Flexibility Act (RFA), 5 U.S.C. §§ 603-605, 607, and 609

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. A change in revenues of more than 3 percent to 5 percent is often used by the Departments of Labor and HHS as the measure of significant economic impact on a substantial number of small entities. The agencies state that, as discussed in the Web Portal interim final rule with comment period published on May 5, 2010 (75 Fed. Reg. 24,481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis for the proposed rule on establishment of the Medicare Advantage program (69 Fed. Reg. 46,866, Aug. 3, 2004). In that

analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for ‘‘small’’ business (currently $35.5 million in annual receipts for health insurance issuers). HHS also used the data from Medical Loss Ratio annual report submissions for the 2012 reporting year to develop an estimate of the number of small entities that offer comprehensive major medical coverage. These estimates by the agencies, may overstate the actual number of small health insurance issuers that would be affected by these regulations, since they do not include receipts from these companies' other lines of business. The agencies estimated that there are 58 small entities with less than $35.5 million each in earned premiums that offer individual or group health insurance coverage and would therefore is subject to the requirements of these regulations. Forty-three percent of these small issuers belong to larger holding groups, and many, if not all, of these small issuers are likely to have other lines of business that would result in their revenues exceeding $35.5 million.

For these reasons, the agencies expect that these final regulations will not significantly affect a substantial number of small issuers. In addition, the agencies certified that the collections of information contained in these final regulations will not have a significant impact on a substantial number of small entities. Accordingly, the agencies determined that a regulatory flexibility analysis is not required.

(iii) Agency actions relevant to sections 202-205 of the Unfunded Mandates Reform Act of 1995 (UMRA), 2 U.S.C. §§ 1532-1535

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a federal mandate that could result in expenditure in any one year by state, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold level is approximately $141 million. According to the agencies, these regulations are not subject to the UMRA because they were not preceded by a notice of proposed rulemaking. However, consistent with policy embodied in the UMRA, these regulations have been designed to be a low-burden alternative for state, local, and tribal governments, and the private sector while achieving the objectives of MHPAEA.

(iv) Other relevant information or requirements under acts and executive orders

Administrative Procedure Act, 5 U.S.C. §§ 551 et seq.

The agencies stated that it has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations.

Paperwork Reduction Act (PRA), 44 U.S.C. §§ 3501-3520

In accordance with the requirements of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)), the interim final regulations solicited comments on the information collections included therein. The agencies submitted an information collection request (ICR) to the Office of Management and Budget (OMB) in accordance with 44 U.S.C. 3507(d), contemporaneously with the publication of the interim final regulations for OMB's review. OMB approved the ICR on April 27, 2010, under OMB Control Numbers 1210–0138 (Department of Labor) and 1545–2165 (Department of the Treasury/IRS). The agencies also submitted an ICR to OMB in accordance with 44 U.S.C. 3507(d) for the ICR as revised by the final regulations. OMB approved the ICR under OMB control numbers 1210–0138 and 1545–2165, which will expire on November 30, 2016.

The agencies included a table summarizing the hour burden and costs related to the disclosure requirements in these regulations organized by plan type. The agencies estimate that there are about 1,258,000 Employee Retirement Income Security Act of 1974 covered health plans affected by the regulations. The labor hours for these are estimated to be 11,976, while the cost burden would be $2,989,000. The agencies estimate that there are about 82,324 Public, Non-Federal Employer Group Health Plans affected by the regulations. The labor hours for these are estimated to be 2,517, while the cost burden would be $1,375,312. The agencies estimate that there are 418 Individual Market Health Plans affected by the regulations. The labor hours for these are estimated to be 25,465, while the cost burden would be $51,066.

The ICRs associated with the medical necessity and claims denial disclosures are currently approved under OMB control number 0938–1080. HHS will seek OMB approval for revised ICRs that will include the burden to small group health plans and individual market plans related to the disclosure requirements in the final regulations. A *Federal Register* notice will be published, providing the public with an opportunity to comment on the ICRs.

Statutory authorization for the final rules

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Internal Revenue Code of 1986.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. sections 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. No. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. No. 105–200, 112 Stat. 645 (42 U.S.C. sect. 651 note); sec. 512(d), Pub. L. No. 110–343, 122 Stat. 3765; Pub. L. No. 110–460, 122 Stat. 5123; Secretary of Labor's Order 1–2011, 77 Fed. Reg. 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. sect. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

Executive Order No. 12,866 (Regulatory Planning and Review)

The Department of Labor and Department of Health and Human Services have determined that this regulatory action is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an effect on the economy of $100 million or more in at least one year. The agencies submitted the interim final rules to OMB for review. The Department of the Treasury, however, did a special analysis and determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12,866, as supplemented by Executive Order 13,563. Therefore, a regulatory assessment by the Department of Treasury was not required.

Executive Order No. 13,132 (Federalism)

In the agencies' view, these regulations have federalism implications, because they have direct effects on the states, the relationship between the federal government and states, or on the distribution of power and responsibilities among various levels of government. However, in the agencies' view, the federalism implications of these regulations are substantially mitigated because, with respect to health insurance issuers, the agencies expect that the majority of states have enacted or will enact laws or take other appropriate action resulting in their meeting or exceeding the federal MHPAEA standards.