

May 3, 2010

Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-4140-IFC

Internal Revenue Service
Department of the Treasury
RIN 1545-BJ05

Employee Benefits Security Administration
Department of Labor
RIN 1210-AB30

RE: Internal Final Rules under the Mental Health Parity and Addiction Equity Act of 2008

Dear Sir/Madam:

I am writing to share The Principal Financial Group's serious concerns with the proposed Interim Final Rules (IFR) for the Mental Health Parity and Addiction Equity Act (MHPAEA) issued by the Department of Health and Human Services, the Department of Labor and the Department of the Treasury. The Principal Financial Group provides insured group health benefits and administrative services only (ASO) plans, covering 743,471 members. The Principal also manages \$32.9 million in HSA assets with 54,146 High Deductible Health Plan members.

Principal has two concerns with the proposed rules and a discussion of each concern follows.

1. Application and Results of the Financial Testing Requirements
2. IFR effective date

IFR – FINANCIAL TESTING REQUIREMENTS

A plan may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant (1/2) financial requirement or treatment limitation applied to substantially all (2/3) medical/surgical benefits in the same classification.

Financial requirements include cost-sharing elements, such as copayment, coinsurance and deductible. The regulation specified six benefit classifications:

Inpatient, in-network
Inpatient, out-of-network
Outpatient, in-network
Outpatient, out-of-network
Emergency care
Prescription drugs

FINANCIAL TESTING REQUIREMENTS – OUTCOME

We have tested all cost-sharing elements for our insured plans in each of the six benefit classifications. Our concern is with the results of the outpatient testing. Outpatient benefits encompass a broad range of services including hospital services, stand-alone outpatient facilities/ambulatory, physician office visits and medical supplies. The services received at the various outpatient locations are typically reimbursed

very differently. For example, physician office visits typically require a member copayment before the plan benefits apply. However, outpatient surgery is generally subject to plan deductible and coinsurance.

As required by the financial testing provisions of the IFR, a plan is unable to apply a cost-sharing element to Mental Health/Substance Use Disorder (MH/SUD) claims if it does not meet the “substantially all” test above. The results of our financial testing show that the coinsurance and deductible cost-sharing categories for our plans meet the substantially all financial testing requirement for the outpatient, in-network classification. However, the copayment cost-sharing category does not meet the substantially all financial testing requirement for the outpatient, in-network classification.

As a result, the regulation does not allow us to apply a copayment to any outpatient MH/SUD services, including physician office visits, even though we apply a copayment to medical/surgical physician office visits under our plans.

The outcome of the testing results is demonstrated in the following example of outpatient, in-network benefits:

- Prior to MHPAEA IFR
 - Medical/Surgical Physician Office Visit – Member pays a \$30 copayment; then benefits are paid at 100% of the covered charges. Deductible and coinsurance do not apply.
 - MH/SUD Physician Office Visit – Member pays a \$30 copayment; then benefits are paid at 100% of the covered charges. Deductible and coinsurance do not apply.
- Post Implementation of MHPAEA IFR
 - Medical/Surgical Physician Office Visit – Member pays a \$30 copayment; then benefits are paid at 100% of the covered charges. Deductible and coinsurance do not apply.
 - MH/SUD Physician Office Visit – Member must meet their annual deductible (example – \$1,000) before any benefits are payable; after the deductible is met, the member pays coinsurance (example – 20%) on the covered charges. This means the member will bear the full cost of each visit before the deductible is met. After the deductible is met, the member will bear the coinsurance cost for each visit.

While we interpret this result to be in compliance with the financial testing requirements, we believe that the increased economic burden on the member is an unintended consequence of the regulations. Not only does this single out MH/SUD physician office visits for different cost-sharing from medical/surgical physician office visits, it also disadvantages individuals with chronic MH/SUD conditions.

In the example above if you assume that each MH/SUD physician office visit has a cost of \$200, an individual who receives a course of treatment for a mental health condition that lasts for 10 visits would pay \$300 under the pre-parity rules (\$30 copayment per visit * 10 visits = \$300). After application of the parity rules, that individual would pay \$1,000 for the first 5 visits (\$200 per visit * 5 visits = \$1,000) to meet their deductible, and then would pay \$200 for the next 5 visits (\$200 per visit * 20% coinsurance * 5 visits = \$200) – representing total out-of-pocket costs of \$1,200.

OVERLAP WITH HEALTH CARE REFORM

With guidance pending on Health Care Reform and the implications of making changes to a “grandfathered” plan unknown, we do not know the potential consequences of revising an existing plan that was in effect prior to March 23, 2010. We hesitate to make changes that might inadvertently cause an otherwise grandfathered plan to lose its status as such.

RESOLUTION REQUEST FOR FINANCIAL TESTING REQUIREMENTS

Our goal is to be in compliance with the Interim Final Rules. In order to resolve the unintended results of the financial testing, we request that two additional classifications be added to the financial testing requirements:

- Clinic/Office Visit – In-network
- Clinic/Office Visit – Out-of-network

The addition of these two classifications would result in a higher degree of parity for clinic/office visits and outpatient services. Again, we believe this is the intent of the statute and is the most equitable result.

We have retested our cost sharing elements with these two proposed categories and have found that all cost-sharing elements on our plans would be in compliance with the Interim Final Rules.

EFFECTIVE DATE

Principal's second concern with the proposed rules is the effective date of the IFR. The timing of the issuance of the IFR and the complexity of the testing requirements has created a hardship for both health plans and employers as they attempt to comply. Renewals are typically planned 3 to 6 months in advance of the renewal date. The regulations are effective as of April 1, 2010 for plan years beginning on or after July 1, 2010. While many health plans have a January 1, 2011 renewal date, July 1, 2010 is the second biggest renewal date. The changes that must be made could be considerable and do not realistically reflect the time needed for system and operational changes.

RESOLUTION REQUEST FOR EFFECTIVE DATE

We are in agreement with AHIP that the compliance date should be extended until plan years on or after July 1, 2011.

We thank you for your consideration of our requests. If you have questions regarding our comments, please contact me or Lucia Riddle, Vice President of our Federal Government Relations office at (202) 682-1280.

Sincerely,

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