RETAIL INDUSTRY LEADERS ASSOCIATION
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1700 NORTH MOORE STREET
SUITE 2250
ARLINGTON, VA 22209
T (703) 841-2300 F (703) 841-1184
WWW.RILA.ORG

May 3, 2010

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

Re: Comments on the Mental Health Parity Act Interim Final Regulations

Dear Sir or Madam:

On behalf of the Retail Industry Leaders Association (RILA), I write in regard to the Interim Final Rule under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). As providers of mental health and substance use disorder benefits for millions of Americans, we appreciate the opportunity to comment.

The Retail Industry Leaders Association promotes consumer choice and economic freedom through public policy and industry operational excellence. Our members include the largest and fastest growing companies in the retail industry – retailers, product manufacturers, and service suppliers – which together account for more than $1.5 trillion in annual sales. RILA members provide millions of jobs and operate more than 100,000 stores, manufacturing facilities and distribution centers domestically and abroad.

We are concerned that the interim final rule reaches beyond the careful balance struck in the MHPAEA. Regulators should seek the same balance between the cost of benefits and the extent of coverage, especially given recent passage of the Patient Protection and Affordable Care Act of 2010 (PPACA). Parity regulations should not discourage the provision of mental health and substance use disorder benefits in any way.

Given the complexity of implementing MHPAEA alongside PPACA, we would urge that a special effort be made to facilitate compliance by employer health plans, insurers and benefit administrators who make a reasonable good faith effort to implement the regulations. Employers will face numerous new requirements through the combination of these two landmark laws and clear guidance and compliance assistance from the regulatory agencies can help advance the transition. We also encourage you to follow the direction of MHPAEA which preserved the right of employers to decide whether to offer mental health and substance use disorder benefits and what conditions and services or treatments to address in their plans. We believe that this flexibility is vital to keeping all benefits more equitable and targeted.

Also, we are greatly concerned by the interim final rule's approach to non-quantitative treatment limits, which we believe is directly counter to the balance struck by Congress in crafting the law. Medical management is crucial to achieving quality and affordable coverage. These techniques do not translate well from medical/surgical practices to mental health and substance use disorder conditions. We urge you to abandon this concept.

Finally, we are concerned that the "substantially all" and "predominant" tests are too inflexible and assume greater uniformity of plan design than is the case. Cost sharing is used not only to encourage better utilization but also to encourage desired behaviors – e.g., smoking cessation. Thus, co pays and coinsurance can vary greatly within a plan. If the goal is to have universally congruent cost sharing, the practical effect may be to increase cost sharing to a level of parity position with mental health and substance use disorder benefits.

Thank you for your attention to these comments and concerns. Please do not hesitate to contact me with additional comments or questions.

Sincerely,

John G. Emling
Senior Vice President, Government Affairs