Supporting Statement
(TD 9640)
1545-2165

1. CIRCUMSTANCES NECESSITATING COLLECTION OF INFORMATION

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Public Law 110-343). MHPAEA amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code). In 1996, Congress enacted the Mental Health Parity Act of 1996 (MHPA 1996), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical and surgical benefits. Those mental health parity provisions were codified in section 712 of ERISA, section 2705 of the PHS Act, and section 9812 of the Code, and applied to employment-related group health plans and health insurance coverage offered in connection with a group health plan. The changes made by MHPAEA were codified in these same sections and consist of new requirements as well as amendments to the existing mental health parity provisions. The changes made by MHPAEA are generally effective for plan years beginning after October 3, 2009.

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010. (They are collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The Affordable Care Act adds section 715(a)(1) to ERISA and section 9815(a)(1) to the Code to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

The Affordable Care Act extended MHPAEA to apply to the individual health insurance market and also designated MHPAEA in the Public Health Service Act as section 2726. Additionally, section 1311(j) of the Affordable Care Act provides that section 2726 of the PHS Act shall apply to qualified health plans (QHPs) in the same manner and to the same extent as such section applies to health insurance issuers and groups health plans. Furthermore, the Department of Health and Human Services (HHS) final regulation regarding essential health benefits (EHB) requires health insurance issuers offering non-grandfathered health insurance coverage in the individual and small group markets, through an Exchange or outside of an Exchange, to comply with the requirements of the regulations of the MHPAEA regulations in order to satisfy the requirement to cover EHB.

2. USE OF DATA

This is a third party disclosure requirement. Participants or beneficiaries requesting medical necessity criteria from a group health plan will be in a better position to evaluate whether the plan followed its criteria in deciding a particular claim by the participant or beneficiary for benefits under the plan.

3. USE OF IMPROVED INFORMATION TECHNOLOGY TO REDUCE BURDEN

Participants and beneficiaries are permitted to make electronic requests for medical necessity criteria, and plans may reply by electronic means if they comply with electronic disclosure requirements.

4. EFFORTS TO IDENTIFY DUPLICATION

Group health plans are currently required under the Employee Retirement Income Security Act (ERISA) to provide individuals seeking a benefit under the plan an explanation of claims denials. Section 9812 of the Code also imposes this obligation with respect to denials of mental health or substance abuse disorder benefits. To avoid duplication, the temporary regulations provide that a plan subject to ERISA complies with that requirement by complying with the ERISA claims procedure requirements. There is no comparable existing requirement to disclose medical necessity criteria used in determining claims for benefits.

5. METHODS TO MINIMIZE BURDEN ON SMALL BUSINESSES OR OTHER SMALL ENTITIES

Employers with not more than 50 employees are not subject to the ICR.

6. CONSEQUENCES OF LESS FREQUENT COLLECTION ON FEDERAL PROGRAMS OR POLICY ACTIVITIES

The consequences are that the IRS will have to spend more taxpayer assistance resources to collect this data through other means. This will compromise the Agency's ability to enforce tax compliance. Tax compliance is a vital part of the government's ability to meet its' mission and serve the public.

7. SPECIAL CIRCUMSTANCES REQUIRING DATA COLLECTION TO BE INCONSISTENT WITH GUIDELINES IN 5 CFR 1320.5(d)(2)

There are no special circumstances requiring data collection to be inconsistent with Guidelines in 5 CFR 1320.5(d)(2).

8. CONSULTATION WITH INDIVIDUALS OUTSIDE OF THE AGENCY ON AVAILABILITY OF DATA, FREQUENCY OF COLLECTION, CLARITY OF INSTRUCTIONS AND FORMS, AND DATA ELEMENTS

On April 28, 2009, the Departments of the Treasury, Labor, and HHS (collectively, the Departments) published in the Federal Register (74 FR 19155) a request for information (RFI) soliciting comments on the requirements of MHPAEA. On February 2, 2010, after consideration of the comments received in response to the RFI, the Departments published in the Federal Register (75 FR 5410) comprehensive interim final regulations implementing MHPAEA (interim final regulations). 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 Departments issued clarifications in several rounds of Frequently Asked Questions (FAQs). In the first FAQ about MHPAEA, the Departments set forth an enforcement safe harbor under which the Departments would not take enforcement action against plans and issuers that divide benefits furnished on an outpatient basis into two sub-classifications – (1) office visits, and (2) all other outpatient items and services – for purposes of applying the financial requirement and treatment limitation rules under MHPAEA.

After consideration of the comments and other feedback received from stakeholders, the Departments are publishing these final regulations.

In response to the Federal Register Notice dated November 27, 2015 (80 FR 74217), we received no comments during the comment period regarding these regulations.

9. EXPLANATION OF DECISION TO PROVIDE ANY PAYMENT OR GIFT TO RESPONDENTS

No payment or gift has been provided to any respondents.

10. ASSURANCE OF CONFIDENTIALITY OF RESPONSES

Generally, tax returns and tax return information are confidential as required by 26 U.S.C. 6103.

11. JUSTIFICATION OF SENSITIVE QUESTIONS

A privacy impact assessment (PIA) has been conducted for information collected under this request as part of the "Business Master File (BMF)" system and a Privacy Act System of Records notice (SORN) has been issued for this system under IRS 24.046-Customer Account Data Engine Business Master File. The Internal Revenue Service PIA's can be found at http://www.irs.gov/uac/Privacy-Impact-Assessments-PIA.

Title 26 USC 6109 requires inclusion of identifying numbers in returns, statements, or other documents for securing proper identification of persons required to make such returns, statements, or documents and is the authority for social security numbers (SSNs) in IRS systems.

12. ESTIMATED BURDEN OF INFORMATION COLLECTION

The final regulations retain the disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan. (In addition, these disclosure provisions are extended to small employers and individual plans as a result of MHPAEA requirements extending to these plans and issuers under the ACA as discussed in section II.E and II.H.1 of the preamble.)

The Departments (DOL& IRS) estimate that there are about 2,284,000 ERISA covered health plans. The Departments estimate that approximately seven percent of large plans and all small plans administer claims using service providers; therefore, only five percent of the medical necessity criteria disclosures will be done in-house. For PRA purposes, plans using service providers will report the costs as a cost burden, while plans administering claims in-house will report the burden as an hour burden.

The Departments assume that it will take a medically trained clerical staff member five minutes to respond to each request at a wage rate of $26.85 per hour. This results in an annual hour burden of nearly 9,500 hours (5,988 IRS related), and an associated equivalent cost of nearly $256,000 for the approximately 114,000 requests done in-house by plans. The remaining 2,170,000 medical necessity criteria disclosures will be provided through service providers resulting in a cost burden of approximately $4,854,000.

These changes will result in an increase in burden by 4,088 hours.

13. ESTIMATED TOTAL ANNUAL COST BURDEN TO RESPONDENTS

The Departments assume that it will take a medically trained clerical staff member five minutes to respond to each request at a wage rate of $26.85 per

hour. This results in an annual hour burden of nearly 9,500 hours and an associated equivalent cost of nearly $256,000 for the approximately 114,000 requests done in-house by plans. The remaining 2,170,000 medical necessity criteria disclosures will be provided through service providers resulting in a cost burden of approximately $4,854,000.

The Departments also calculated the cost to deliver the requested medical necessity criteria disclosures. Many insurers and plans already may have the information prepared in electronic form, and the Departments assume that 38 percent of requests will be delivered electronically resulting in a de minimis cost.

The Departments estimate that the cost burden associated with distributing the approximately 1,416,000 medical necessity criteria disclosures sent by paper will be approximately $916,000.

As suggested by OMB, our Federal Register Notice dated November 27, 2015, requested public comments on estimates of cost burden that are not captured in the estimates of burden hours, i.e., estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. However, we did not receive any responses from taxpayers on this subject. As a result, estimates of these cost burdens are not available at this time.

14. ESTIMATED ANNUALIZED COST TO THE FEDERAL GOVERNMENT

There are no annualized costs to the Federal government.

15. REASONS FOR CHANGE IN BURDEN

This document contains final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 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 regulations retain the disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan.

These changes will result in an increase in burden by 4,088 hours.

16. PLANS FOR TABULATION, STATISTICAL ANALYSIS AND PUBLICATION

There are no plans for tabulation, statistical analysis and publication.

17. REASONS WHY DISPLAYING THE OMB EXPIRATION DATE IS INAPPROPRIATE

We believe that displaying the OMB expiration date is inappropriate because it could cause confusion by leading taxpayers to believe that the regulation sunsets as of the expiration date. Taxpayers are not likely to be aware that the Service intends to request renewal of OMB approval and obtain a new expiration date before the old one expires.

18. EXCEPTIONS TO THE CERTIFICATION STATEMENT

There are no exceptions to the certification statement.

Note: The following paragraph applies to all of the collections of information in this submission:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.