Baum, Beth - EBSA

From: Sheryl Bonner [sheryl@boonchapman.com]
Sent: Friday, March 12, 2010 10:30 AM
To: EBSA, E-OHPSCA - EBSA
Subject: Comment on MHPAEA Interim regulations

We have a client who has a $350 copay for outpatient hospital/ancillary charges for combined mental health and medical benefits. Their attorney understands the regs to mean the following:
The Schedule provides that there is a $350 copay for outpatient hospital / ancillary charges for combined mental health and medical benefits. These items would comply with the MHPAEA regulations if: (1) at least two-thirds of outpatient medical/surgical benefits (based on the Plan' s payments) are subject to a copay, and (2) of the two-thirds of the outpatient medical/surgical benefits that are subject to a copay, more than 50% of the medical/surgical benefits have a copay of at least $350. If th at's true, then under the regulations the Plan would be permitted to have a $350 copay for outpatient hospital / ancillary charges for mental health conditions.

How do we go about conducting this "test"? Do we use historical data?

Can you provide a real life example of how this provision works?

Thanks