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Request for Information for Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: IRS-2009-0008-0120
Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: IRS-2009-0008-0152
Comment on FR Doc # 2010-02167

Submitter Information

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Organization: Mental Health Parity Work Group of the American Academy of Actuaries

General Comment

Attached are comments from the American Academy of Actuaries' Mental Health Parity Work Group on the interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Attachments

IRS-2009-0008-0152.1: Comment on FR Doc # 2010-02167

AMERICAN ACADEMY *of* ACTUARIES

May 3, 2010

Room 5205
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: CC:PA:LPD:PR (REG-120692-09)

To Whom It May Concern:

On behalf of the American Academy of Actuaries' Mental Health Parity Work Group, I am submitting the following comments and requests for clarification in response to the request for comments on the interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

In addition to the comments and requests for clarification below, we would like to point out that there are some significant timing issues. Many entities have already begun working on July 2010 and subsequent plan renewals, including benefit changes and revised rates, and will likely need to complete such work before receiving further guidance and clarification from the Departments. As such, retroactive changes will likely need to be made to comply with these regulations.

Question 1: The interim final rules do not allow comparing copays to coinsurance (and vice versa) in the determination of whether a financial requirement meets the 'substantially all' and 'predominant' levels for medical/surgical benefits. In the outpatient in-network class, it is common for health plans to use both copays and coinsurance for different service categories. In some benefit designs, the majority of outpatient medical/surgical benefits are subject to either coinsurance or copays, but neither the copay or coinsurance 'type' on its own will satisfy the 'substantially all' test. In the most extreme case, 65 percent of outpatient medical/surgical benefits could be subject to coinsurance, 35 percent could be subject to copays, but a strict application of the rules would conclude with neither copays nor coinsurance being applicable for the behavioral health care benefits.

Can copays and coinsurance be combined in this testing using actuarially equivalent values? This would include either the conversion of copays to equivalent coinsurance levels or the conversion of coinsurance to equivalent copay levels using average allowed costs by type of service. The following simple example illustrates this.

Description	% of Plan Payments	Average Allowed Charge/Service	Coinsurance Level	Copay Level	Equivalent Coinsurance	Equivalent Copay
OP Benefits Subject to Coinsurance	65%	$100	20%	NA	NA	$20
OP Benefits Subject to Copays	35%	$100	NA	$25	25%	NA

After determining the actuarially equivalent levels, testing either copays or coinsurance would result in the satisfaction of the 'substantially all' criteria. The 'predominant' level for using copays would be $20 for the behavioral benefits, and the 'predominant' level using coinsurance would be 20 percent for behavioral benefits.

Question 2: How would the rules apply to benefit plans with a three-tier benefit design? For example, preferred benefits are provided in three tiers:

- For providers in tier 1—no coinsurance, lower benefits apply for all other network hospitals;
- For providers in tier 2—10 percent coinsurance, and out-of-network benefits apply for all non-network hospitals; and
- All other providers in tier 3—30 percent coinsurance.

Is it a correct interpretation that the rules require testing each tier separately?

Question 3: Some plans have a single-episode copay for all services obtained in an office visit. For example, a single copay could apply for an office visit, some lab work, a few x-rays and a stress test if they are all provided during the same office visit. Is it compliant with MHPAEA to include all of these medical/surgical services as being subject to copays in the 'substantially all' testing, or should it include only the office visit service as having a copay?

Question 4: In the interim final rules, under *Clarifications for certain threshold requirements* (p.5448), it is noted that "for any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible *if it had not been satisfied.*" [emphasis added] This indicates that the test for deductibles would be before consideration of member cost sharing, hence on an allowed basis. Please confirm that the intent of the MHPAEA interim final rules is that the determination of 'substantially all' levels and 'predominant' levels are based on allowed plan costs rather than paid plan costs.

Question 5: The testing of the out-of-pocket limit financial requirement could lead to higher levels of out-of-pocket maximums for behavioral health care benefits, which is inconsistent with the intent of MHPAEA. For example, if a plan has a $500 deductible with the member paying 20 percent after a $100 deductible, subject to a maximum of $1000 out-of-pocket (including the $100), and the member has a claim of $10,000 in allowed charges (and no other claims have been incurred in that year), then the claim would be treated the following way:

The member pays $100 deductible leaving $9,900. The $9,900 is split 20/80 but the member's share is capped at $900 due to the out-of-pocket maximum (because he/she has already paid $100 in deductible). So, 20 percent of $9,900 would be $1,980, which exceeds the out-of-pocket maximum ($900 left after $100 deductible). Therefore, the plan pays 80 percent of $9,900 ($7,920) PLUS what exceeds the out-of-pocket maximum ($1,080).

The result with the out-of-pocket maximum is that the plan pays $9,000 and the member pays $1,000.

The result with no out-of-pocket maximum is that the plan pays $7,920 and the member pays $2,080.

In other words, if there is not an out-of-pocket maximum applied to mental health benefits, the member would pay an additional portion of the payment ($1,080), which would be an unintended result of MHPAEA.

Question 6: If a plan provides a smoking cessation program via a benefit rider that offers counseling benefits and some over-the-counter medications, but does not cover a brand name drug for nicotine addiction (e.g., Chantix), would the plan be non-compliant unless they could determine that excluding Chantix on their formulary placement follows a comparable procedure to their placement criteria for 'substantially all' of their medical/surgical drugs on their formulary? Please confirm that having a treatment limit for Chantix is a quantitative treatment limitation, which is non-compliant with MHPAEA if 'substantially all' of their medical/surgical drugs do not have comparable treatment limits. Furthermore, please confirm that having a pre-authorization requirement for Chantix (which is also required in counseling for tobacco cessation), but not something comparable for 'substantially all' medical/surgical drugs on the formulary, is a non-quantitative treatment limitation, which is non-compliant with MHPAEA.

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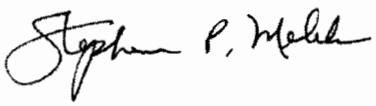
We would appreciate the opportunity to discuss any of these items with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,



Stephen P. Melek, MAAA, FSA
Mental Health Parity Work Group
American Academy of Actuaries