AMERICAN ACADEMY *of* ACTUARIES

Comments of the American Academy of Actuaries on the Notice of Interim Rules to Administer the Mental Health Parity Act of 1996

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The American Academy of Actuaries is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. The Academy assists the public policy process through the presentation of clear actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to senior federal elected officials and congressional staff, comments on proposed federal regulations, and works closely with state officials on issues related to insurance.

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INTRODUCTION

The American Academy of Actuaries (the "Academy") Mental Health Parity Work Group (the "Work Group") hereby submits comments on regulations proposed in the Notice of Interim Rules to administer the Mental Health Parity Act (hereafter referred to as "MHPA" and "the Act") issued jointly by the Department of Treasury, Department of Labor, and Department of Health and Human Services. On December 22, the agencies charged with enforcement of the MHPA requirements published proposed rules in the Federal Register. These rules are documented in interim rules in Internal Revenue Service REG-109704-97 and TD 8741, issued jointly by the Health Care Financing Administration and the Pension Welfare Benefits Administration. The proposed regulations, if adopted, would require group health plans that provide mental health coverage to apply the same aggregate lifetime and annual dollar limits to mental health services as are currently applied for medical and surgical benefits. The Work Group suggests three areas of improvement to the rules: (A) modification of the calculation of the one percent increased cost exemption; (B) modification of the methodology for determining a plan's allowable mental health benefit limits; and (C) clarification of some terms used in the rules. Our suggestions include recommendations that certain calculations be supported by accepted actuarial standards. Further, in order to protect the integrity of the cost estimates developed under the proposed rules, the calculations should be done in accordance with accepted actuarial standards.

Statement of Interest

The Academy is a nonprofit professional association established in 1965 to provide a common membership organization for actuaries of all specialties (life, health, casualty, and pension) practicing within the United States. Its mission includes ensuring that "the American public benefits from the independent expertise of the actuarial profession." The Academy's primary activities include: promulgation and implementation of professional standards of conduct, practice and qualification; liaison with federal and state governments; relations with other professions; and dissemination of public information about the actuarial profession.

The Academy's membership exceeds 12,000 actuaries nationwide. These actuaries are expert in the projection, quantification and management of risk. As professionals providing services to pension plans, insurers, financial institutions and government bodies, actuaries are uniquely cognizant of the issues involved in designing and selling products without careful analysis and planning to manage the risks involved.

A. CALCULATION OF THE ONE PERCENT COST EXEMPTION

The proposed interim rules describe a method for determining whether the implementation of the Act has caused an increase of at least one percent in the cost of a group health plan (or health insurance coverage). The proposed interim rules outline how group health plans can exempt themselves from the requirements on the basis that a one percent or higher increase in employer benefits costs results after complying with the law for six months. Under the exemption process outlined in this rule, plans can exercise an exemption after six months as soon as they document a one percent or higher cost increase and provide a 30 day notice to participants and the federal government. The Work Group is suggesting several changes to these provisions of the rules.

1. The proposed rules define incurred expenditures as including "actual claims incurred during the base period and reported within two months following the base period..." This definition

presumes that all incurred claims will be submitted within two months after incurral. Claim submission and payment patterns within a plan vary by type of benefit (e.g., inpatient claims vs. prescription drug claims). Across plans, claim submission and payment patterns vary according to the plan provisions and the plan administrators' business practices. If the intent of the legislation is to measure incurred claims, the Work Group suggests that the rules allow plans to measure the claim portion of incurred expenditures in either of two alternatives:

a. actual claims incurred during the base period and reported within a period of *not less than* two months following the base period, or

b. actual claims incurred during the base period, reported within a period of not less than two months following the base period, plus an actuarially-certified estimate of incurred but not reported claims.

2. The length of the base period studied and the size of the plan affect credibility. The Work Group suggests that the Act consider allowing incurred expenditures to be calculated using credibility adjustments according to actuarially accepted methods.

3. The proposed rules define the length of the base period as at least six months. Such a short base period may not reflect the seasonality typically experienced in claim submission and payment patterns. Additionally, there is a larger statistical variation in claim incurrals over short periods of time. This is especially important for smaller plans and for moderate size employers that have more than one plan (since the incurred expenditure calculation must be performed separately for each plan. 4. The proposed rules state that incurred expenditures do not include premiums. However, for a fully insured plan, the change in the cost of the plan (to the employer and to the covered employees) should be the premium paid to the issuer of the coverage. The Work Group suggests that the rules define the "change in cost" for a fully insured plan to be the change in

premium resulting from the application of the Act. This can be determined in advance of a plan year. Similarly, capitation payments for any type of benefit (rather than the actual claims for that benefit) should be part of the measurement of incurred expenditures.

5. The proposed rules state that incurred expenditures include administrative expenses. The Work Group suggests that the rules should clearly state the components of the cost of administration attributable to complying with the requirements of the Act. For example, can those costs include a prospective estimate of the cost of notifying employees of a plan's exemption from the Act? Some costs of complying with the Act will be difficult to determine. For example, plan amendments and system enhancements may include complying components as well as components unrelated to the Act. The Work Group suggests that the rules provide guidance for attributing expenses to the Act. In the absence of supplying an exhaustive list of expenses, the Act may want to suggest a safe harbor expense level (for example, 15 percent of incurred expenditures). The Work Group would be happy to assist in determining such a safe harbor level.

6. The Act requires that the cost of compliance be measured separately for each benefit package of a group health plan. This requirement can lead to adverse selection and unintended cost consequences. For example, if a plan has two benefit packages, and if one of the benefit packages becomes exempt because of a cost increase of at least one percent, the plan participants who anticipate having high mental health costs will tend to choose the non-exempt benefit package. This could (at least temporarily) drive up the cost of the non-exempt benefit package.

B. DETERMINING THE ANNUAL OR LIFETIME LIMIT FOR MENTAL HEALTH BENEFITS BASED ON MEDICAL/SURGICAL COVERAGE LIMIT(S)

The proposed interim rules describe methods for determining whether or not a group health plan (or health insurance coverage) may impose aggregate annual and/or lifetime limits on mental health benefits; and, if so, how the limits are to be determined. The Work Group is suggesting several changes to these provisions of the rules.

1. The Act uses the phrase "substantially all" to describe the extent to which a plan (or coverage) includes limits on medical and surgical benefits. The proposed interim rules define "substantially all" as being at least two-thirds. However, the reasoning behind this definition of "substantially all" is not clear in the rules, and two-thirds figure may, in fact, be too low.

2. The proposed rules state that the determination of the "substantially all" breakpoints (defined therein as one-third and two-thirds of medical/surgical benefits), and the determination of the weights to be used in the weighted average benefit limit, are to be based on the dollar amount of expected paid medical/surgical benefits. The expected dollar amounts may be determined using any reasonable method. The Work Group suggests that the rules specify that "any reasonable method" must be based on accepted actuarial standards.

3. The Work Group suggests that the determination of the breakpoints be based on the dollar amount of medical/surgical benefits expected to be *incurred in the absence of existing plan (or coverage) limits*, rather than on the expected paid benefits taking into account the existing limits. This would tend to produce a larger fraction than would be produced under the definition in the interim rules. The latter definition attributes already-limited benefit dollars to the covered services that have

benefit limits. In addition, the use of incurred benefit dollars produces a more accurate comparison of costs across benefit types than does the use of paid dollars.

4. The proposed rules state that, for purposes of determining weighted averages, any benefits that are not within categories subject to plan limits are to be aggregated using a reasonable estimate of the upper dollar limit the plan may be expected to incur. The Work Group suggests including in the rules specified maximum "safe harbor" annual and lifetime dollar amounts (such as $2 million and $5 million) that can be used for the aggregate of benefits that are not within the categories subject to plan limits. These specified maximums would be of particular help to smaller plans, for which reasonable estimates of upper limit dollar claims are difficult to determine. Plans should be able to use higher expected upper dollar limits if those limits are actuarially certified.

5. The Work Group suggests that the rules allow, but not require, a plan to apply these maximum "safe harbor" limits to any benefits for which the stated plan limit is larger. For example, a benefit that has a $10 million annual limit could be treated (for purposes of determining a weighted average annual limit) as if it had a $2 million annual limit. This would allow, but not require, a plan that has some very high (but limited) medical/surgical benefits to avoid the anomalous situation of having to provide greater mental health benefits than a plan that has no limits on the same medical/surgical benefits.

6. The proposed rules state that weighted averages are to be determined based on plan limits applicable to medical/surgical "categories." The rules cite two examples of things that are <u>not</u> considered to be categories. The Work Group suggests that the rules provide more guidance in this area. Guidance could take the form of a definitive list of things that are not categories for this purpose. Alternatively, a more complete definition of what a category <u>is</u> could be provided.

C. CLARIFICATION OF CERTAIN TERMS

Some of the items defined or described in the proposed rules warrant further clarification. Specifically, the Work Group suggests that the rules address the items listed below, some of which are also discussed in previous sections of this letter.

1. Administrative Costs

The proposed rules state that the cost of complying with the Act should include administrative costs. As discussed in Section A.4. of this letter, the Work Group suggests that the rules provide more guidance in defining and measuring and/or estimating these expenses.

2. Definition of Plan

The Work Group suggests clarifying the definition of "plan." The proposed rules do not clearly define "plan." For consistency, the Work Group suggests using the same definition as is used for the annual report of employee benefits plans, such as the same EIN/plan number combination that is used on Form 5500.

Without such clarification in definition, several questions emerge. For example: What happens if an employer establishes two employee benefits plans: one that excludes mental health benefits and another that includes only mental health benefits? Are these considered one plan or separate plans? Does the answer vary depending on how plan participants can choose their coverage (e.g., can they elect to participate or not participate in each plan separately, or can they only choose the combination of the two plans as a package)?

3. Definition of Category of Benefits

The Work Group also suggests that the rules clarify whether carved-out benefits (e.g., prescription drugs) are considered separate benefit categories. For example, two employers (Employer A and

Employer B) with identical employee populations and benefit plans could treat the coverage of prescription drugs differently. In this example, the plan of Employer A includes outpatient prescription drugs as part of its "medical plan", while the plan of Employer B includes outpatient prescription drug plan as a carved-out benefit. The rules should clarify how the two situations are treated.

4. Definition of Types of Benefits

There are several places in the proposed rules where the treatment of chemical dependency benefits is not clear (specifically, whether or not chemical dependency benefits should be included with medical/surgical benefits). The Work Group suggests clarifying the treatment of chemical dependency benefits in all instances where they refer to medical/surgical or mental health benefits. Some benefits for mental health coverage and medical/surgical coverage may be capitated. The Work Group suggests that for any capitated benefits, the cost of those benefits be defined as the capitation fee plus applicable administrative expenses.

5. Separate Benefit Packages

The Work Group suggests that the rules provide more guidance in determining when a plan has separate benefit packages. For example, if active employees and retirees have identical benefits, but have different contribution requirements, does the plan have one or two benefit packages?

CONCLUSION

In conclusion, the Work Group believes that the rules can be improved by making three areas of changes: (A) modification of the calculation of the one percent increased cost exemption; (B)

modification of the methodology for determining a plan's allowable mental health benefit limits; and (C) clarification of some terms used in the rules.

The Work Group appreciates this opportunity to provide comments on the interim MHPA rules, and stands ready to respond to questions.