Mental Health Parity Testing
Sample Company
Executive Summary

Sample Company’s self-funded medical plan, currently administered by Sample Third Party Administrator, is not compliant with the regulations of the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008. Regulations require that the level of financial requirements and limitations that are predominant and apply to substantially all mental health and substance use disorder benefits cannot be more restrictive than those that apply to medical and surgical benefits. The copay requirement for outpatient, in-network office visits is currently higher for mental health visits than it is for medical benefits. To become compliant with regulations, the copays for medical office visits must be at least as high as the copay for mental health office visits. I recommend that you immediately begin discussions with your plan administrator to change your copay requirements to bring your plan into compliance. The plan satisfies all other “predominant and substantially all tests”, the results of which are shown below. For a more in-depth discussion of these tests, please refer to the following page. My analysis is subject to the disclaimers provided at the end of this report.

<table>
<thead>
<tr>
<th></th>
<th>Mental Health and Substance Use Disorder</th>
<th>Medical and Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient, in-network</td>
<td>$500 Deductible, 10% Coinsurance</td>
<td>$500 Deductible, 10% Coinsurance</td>
</tr>
<tr>
<td>Inpatient, out-of-network</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient, in-network (Office Visits)</td>
<td>$50 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Outpatient, in-network (Not Office Visits)</td>
<td>$500 Deductible, 10% Coinsurance</td>
<td>$500 Deductible, 10% Coinsurance</td>
</tr>
<tr>
<td>Outpatient, out-of-network</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>3-Tier Copay Structure</td>
<td>3-Tier Copay Structure</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$500 Deductible, 10% Coinsurance</td>
<td>$500 Deductible, 10% Coinsurance</td>
</tr>
</tbody>
</table>
Overview of the Mental Health Parity and Addition Equity Act of 2008

The paragraphs below summarize the current regulations related to mental health and substance use disorder benefits. They are based on my best understanding of the regulations and do not represent a comprehensive treatment of the subject. The full text of the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008 (MHPAEA) is available online as part of the Electronic Code of Federal Regulations.

MHPAEA does not require employers to offer mental health or substance use disorder benefits. However, if employers do offer these benefits they must comply with all requirements contained in the Act.

MHPAEA does not apply to small employers (those with 50 or fewer employees) or retiree only plans (those with less than two active employees).

Non-governmental employers with self-funded plans can file an exemption election with the Centers for Medicare and Medicaid Services (CMS). Employers can also claim an exemption if costs are expected to increase by more than 2% in the first year that MHPAEA applies or 1% in later years. The cost exemption can only be used every other year.

The form of financial requirement or limitation that applies to more than 2/3 of all services is considered to cover substantially all services. The level of the requirement (such as dollar amount, coinsurance percentage, etc.) that applies to more than half of services is considered predominant. The predominant level of benefit that applies to substantially all mental health and substance use disorder benefits cannot be more restrictive than that which applies to medical and surgical benefits.

The “predominant and substantially all tests” are applied to six classifications: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) prescription drugs, and (6) emergency care. If a plan fails a test for outpatient benefits, that classification may be subdivided into (1) office visits and (2) all other benefits. This subdivision wasn’t included in the original Act, but is based on a Department of Labor safe harbor.

MHPAEA prohibits lifetime or annual limits for mental health or substance use disorder benefits that do not also apply to medical and surgical benefits.

If there are cumulative financial requirements which benefits accrue towards (including deductibles and out-of-pocket maximums), mental health and substance use disorders cannot have separate requirements.

MHPAEA also requires that nonquantitative benefits for mental health and substance use disorder be no more restrictive than those for medical and surgical benefits. This includes medical management standards, formulary designs, standards for provider admission to networks, methods for determining charges, step therapy protocols, and exclusions for failure to complete a course of treatment.
Actuarial Certification and Disclaimers

I, Michael Taylor, am an Associate of the Society of Actuaries, an Associate of the Conference of Consulting Actuaries, and a Member of the American Academy of Actuaries. I meet the education and experience requirements of the U.S. Qualification Standards, as issued by the American Academy of Actuaries, necessary to perform this analysis.

My analysis was conducted in accordance with all applicable Actuarial Standards of Practice, as issued by the Actuarial Standards Board.

This report summarizes the results of a mental health parity testing analysis prepared by Liability Analytics, LLC for Sample Company. The figures contained in this report are intended to ensure that the Sample Company plan is compliant with the mental health parity tests outlined in the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008. These figures are not intended for any other purpose.

The intended audience for this report is the management of Sample Company. This report contains confidential information and should not be distributed to any other party without permission from Sample Company. If this report is provided to any other party, it should be provided in its entirety.

The conclusions of this report represent my best estimate of the plan’s compliance taking into account the plan descriptions and experience. I offer no guarantee of compliance should regulators test your plan and draw different conclusions.

This report was created using claims data and a summary plan description as provided by Sample Company. Claims data included experience from the period from January 1, 2010 through December 31, 2010. It was assumed that the claims incurred in this experience period were a suitable approximation of the claims expected for the period beginning January 1, 2012. Data was checked for reasonableness, but no attempt was made to audit the data.

Future plan amendments are not anticipated and have not been valued. Changes in plan design could invalidate the results of this report.

This report supersedes any estimates or drafts previously provided.

Nothing within this report should be considered as accounting, tax, investment, or legal advice.

There is no conflict of interest which would interfere with the objectivity of my work.

February 1, 2012

Date

Michael S. Taylor, ASA, ACA, MAAA