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Submitted electronically via the Federal Rulemaking portal @ www.regulations.gov

Attention: Mental Health Parity and Addiction Equity Act of 2008 Comments
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Dear Sir or Madam:

Subject: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (RIN 0938-AP65)

Hewitt Associates (Hewitt) welcomes the opportunity to submit comments to the Employee Benefits Security Administration (EBSA) regarding the request for information to help the development of regulations regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (the Act).

Who We Are

Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt consults with companies to design and implement a wide range of human resources, retirement, investment management, health management, compensation, and talent management strategies. As a leading outsourcing provider, Hewitt administers health care, retirement, payroll, and other HR programs to millions of employees, their families, and retirees. With a history of exceptional client service since 1940, Hewitt has offices in 33 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit www.hewitt.com.

Hewitt welcomes the opportunity to submit our comments for EBSA's consideration. Hewitt has identified areas of the Act that we believe need clarification to facilitate compliance with the new law and have suggested solutions related to the identified issues to help EBSA in its effort to develop regulatory guidance.

Areas of the Act That Require Guidance

The Act states that the financial requirements and treatment limits applicable to mental health or substance use disorder (MH/SUD) benefits can be no more restrictive than the predominant financial requirements and treatment limits applied to substantially all medical and surgical benefits covered by the plan (or coverage in the case of health insurance), and there can be no separate cost-sharing requirements that are applicable only with respect to mental health or substance use disorder benefits.

1. Under the regulations in the Mental Health Parity Act of 1996, the analysis of whether a group health plan complied with the Mental Health Parity Act of 1996 was made on the basis of benefit packages offered by the group health plan. ERISA Reg. section 2590.712(c) states as follows:

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> *If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.*

While we think this is clear for insured options due to the reference to "health insurance coverage," Hewitt suggests that final regulations under the Act include the application of the Act on the basis of each separate benefit package offered by the group health plan (whether insured or self-insured). Ideally, employers should be given the flexibility to analyze parity based on the benefit package within the "plan" as defined by ERISA that has the highest enrollment or on a benefit package-by-benefit package basis.

2. The Act does not adequately define the terms "substantially all" and "predominant." Specifically, while the Act defines "predominant" as the most common or frequent of such type of limit or requirement, additional guidance is needed on whether this means based on the design of a plan or benefit package, or the most frequently utilized medical and surgical limit or requirement. We expect that EBSA has considered this and will define the terms in upcoming regulatory guidance. It will be most helpful to employers if the terms can be defined based on the design and limits of the plan with the most enrollment, determined using the most recently available data for a plan year at reasonable expense.

3. Hewitt suggests that the final regulations permit plans to satisfy the Act by applying separate but identical deductible, coinsurance limits, and out-of-pocket maximums to MH/SUD benefits and medical and surgical benefits. In addition, Hewitt suggests that the final regulations permit the use of one common deductible, coinsurance limit, and out-of-pocket maximum against which expenses for medical and surgical benefits and MH/SUD benefits may be applied.

4. Many employers offer employees health care options under a group health plan in which the coverage for MH/SUD benefits is "carved out" from the medical design, with one uniform MH/SUD design across several medical options that have varying deductible, coinsurance, and out-of-pocket limits. Thus, the resulting health care option could have a MH/SUD benefit design that differs from the medical/surgical design. Hewitt suggests that the final regulations provide that, for parity purposes, the "predominant" limits applied to "substantially all" benefits under such a plan be determined on the basis of the option (i.e., benefit package) within the plan that has the most number of enrollees.

5. Regarding copayments, the Act does not define whether a behavioral health care provider is considered a primary care physician (PCP) or a specialist. In Hewitt's experience, behavioral health care providers are generally considered to be specialists. Hewitt suggests that the final regulations provide that a plan's copayment schedule will satisfy the Act if the copayment for a behavioral health care provider is not greater than the copayment for a medical/surgical health care provider who is a specialist.

6. In requiring financial parity between the design for MH/SUD benefits and the design for medical/surgical benefits, the Act does not specifically prohibit a plan from satisfying the financial requirements of the Act on the basis of actuarial equivalence. Therefore, Hewitt suggests that the final regulations permit a group health plan to satisfy the Act's financial parity requirements on the basis of actuarial equivalence.

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For example, an actuarially equivalent design would meet the financial parity requirement if 80% coinsurance for outpatient mental health services is equivalent to a $15 copayment for medical services.

7. A group health plan often requires an employee to access the services of an employee assistance program (EAP) before being entitled to MH/SUD benefits from the group health plan. In this case, the EAP functions as a referral service rather than a group health plan. As the EAP is not a group health plan, Hewitt suggests that the final regulations should not deem this requirement to be a financial or treatment limit requiring parity between the MH/SUD benefits and the medical/surgical benefits.

8. The Act requires that a plan that provides out-of-network coverage for medical or surgical benefits must also provide out-of-network coverage for MH/SUD benefits. However, current law permits medical and surgical benefit plans that provide in-network and out-of-network coverage to cover specific medical services in-network but not out-of-network. For example, many plans offer only in-network coverage for annual physical exams (adult and child), immunizations, infertility, and transplants, Accordingly, Hewitt suggests that the final regulations permit plans the flexibility to cover certain MH/SUD services on an in-network basis only. Such services could include, but not be limited to, intensive outpatient programs, residential treatments, and halfway house/group home settings.

9. Hewitt suggests that the final regulations address: 1) the application of the Act to the use of penalties for failure to precertify treatment—specifically, whether a precertification penalty is a financial requirement or a treatment limitation under the Act; and 2) whether penalties for noncompliance with a treatment program—e.g., a financial penalty applied to a member in a substance abuse detoxification or rehabilitation program for not completing the treatment—constitute financial requirements or treatment limits under the Act.

10. Hewitt suggests that the final regulations address whether age limitations on certain types of treatment—e.g., speech therapy up to age 2; autism services up to age 5—constitute financial requirements or treatment limitations under the Act.

Conclusion

We look forward to your guidance in these areas. Please feel free to contact us with any comments or questions related to the matters discussed in this letter.

Sincerely,

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