The Mental Health Parity and Addiction Equity Act: Key Elements and Implications for Smoking Cessation

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The information contained in this document is not legal advice, and should not be considered a substitute for consultation with your own actuaries and other advisors. Please always be sure to consult your counsel to determine whether your benefit plans are compliant with the Act and regulations.

MHPAEA Overview

1. What is the MHPAEA and why was it created?

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was created to bring insured health care benefits for mental health and substance use disorders in line with those for medical/surgical benefits. Historically, health insurance plans have provided more limited benefits for treatment of mental health and substance use disorders, often including calendar year, lifetime, or other quantity limits on coverage. Additionally, it has been common for health insurers to require higher out-of-pocket payments from insured members to access these benefits. The MHPAEA extends the parity requirements that were introduced in the Mental Health Parity Act of 1996 to substance use disorders, and also requires the total integration of mental health and substance abuse disorder coverage with medical/surgical coverage.

2. Does MHPAEA require mental health and substance use disorder coverage?

MHPAEA does not require that group health plans provide mental health or substance use disorder benefits. MHPAEA states that, if a group health plan does provide such benefits, the benefits must be provided at a level consistent with other medical and surgical benefits.[1]

3. Which plan sponsors and group health plans are subject to MHPAEA?

These new rules apply to group health plans (both fully insured and self-insured plans) covering more than 50 employees, Medicaid-managed care plans, Taft-Hartley group health plans, SCHIP programs, and federal employee benefits plans. They also apply to nonfederal government employers that provide self-funded group health plan coverage to their employees, but such employers may elect to opt out from the requirements of MHPAEA.[i2]

4. How does the MHPAEA measure parity?

MHPAEA defines 6 classifications of benefits that each require parity compliance: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. If a plan has no network of providers, all benefits in the classification are characterized as out-of-network. If coverage for mental health and substance use disorders is provided in 1 classification, it must be provided in each of the 6 benefit classifications where medical/surgical coverage is provided.[ii3]

Within each of the benefit classifications, financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations must be tested for parity. Financial requirements are the deductibles, copayments, etc. Quantitative treatment limits are limits on the frequency of treatment, number of outpatient visits, or other similar limits on duration of treatment. Nonquantitative treatment limitations are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment, such as requirements for using lower-cost therapies before a plan will cover more expensive therapies, conditional benefits on completion of a course of treatment medical management standards, standards for provider admission to participate in a network, etc.[4]

[1] 75 Federal Register 5410, 5437 "Scope"

[2] *Id* at 5437 "Applicability"

[3] *Id* at 5432-5433 "Parity Requirements with Respect to Financial Requirements and Treatment Limitations"

[4] *Id* at 5431 "Meaning of Terms"

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5. When do MHPAEA and accompanying Interim Final Regulations go into effect?

The MHPAEA was passed on October 3, 2008, and became effective for plan renewals on or after October 3, 2009. The Interim Final Rules (IFR) providing detailed regulations for MHPAEA were issued on January 29, 2010, and are effective for plan renewals on or after July 1, 2010. Collective bargaining contracts must comply with the IFR starting on their first renewal after July 1, 2010, or after the end of their current collective bargaining contract period. Many group plans renew at the start of each calendar year; therefore many plans will be subject to the IFR starting January 1, 2011. Good faith compliance with MHPAEA is allowed prior to the effective date of the IFR.[iii5]

6. Who is responsible for ensuring compliance with MHPAEA?

Self-insured group plans: The responsibility largely rests with the employer that sponsors the coverage, although it is likely that input would be obtained from their benefit consultants, lawyers, and health plans that provide administrative services.

Fully insured group plans: The responsibility rests on the health plan that sells the fully insured group coverage, with compliance testing including both actuarial and legal analysis.[6]

7. How should benefits be reviewed for compliance if they are administered by different providers?

The parity requirements must be tested for every combination of medical/surgical coverage and mental health and substance use disorder coverage that participants can simultaneously receive. Coverage is tested as if the benefits are a single plan offering even if the benefits are provided by different vendors (including health plans, PBMs, or managed health organizations). Coverage is tested as if the benefits are a single plan offering even if the benefits are offered through an optional rider.[7]

8. What happens if a plan sponsor or group health plan is not compliant with MHPAEA?

An excise tax may be imposed for noncompliance with MHPAEA of up to $100 per covered member per day. This would extend to both insured employees and their covered dependents.

9. Which organizations are responsible for enforcing MHPAEA?

MHPAEA will be enforced jointly by the Internal Revenue Service within the U.S. Department of Treasury, Employee Benefits Security Administration within the U.S. Department of Labor, and by the Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services.

10. Do benefits offered through an employee assistance program (EAP) qualify?

EAP benefits are separately packaged employee benefits that are not likely to be considered part of the insured health care benefits under MHPAEA. A plan may not require that EAP benefits be exhausted prior to receiving mental health and substance use disorder benefits in the insured health care coverage. That requirement is considered a nonquantitative treatment limitation and would be noncompliant with MHPAEA.[8]

11. Will there be any further guidance on MHPAEA?

It is likely that additional guidance will be forthcoming from the federal agencies. The federal agencies specifically requested input from industry on several items (the comment period ended May 3, 2010). Additionally, the federal agencies indicated they will issue guidance related to the increased cost exemption under MHPAEA.

Smoking Cessation and MHPAEA

12. Is smoking cessation covered under MHPAEA?

Smoking cessation is covered under MHPAEA if it is considered treatment for a covered substance use disorder under the health plan's provisions. The IFR does not define which conditions are considered mental health or substance use disorders. It

[5] *Id* at 5437 "Effective/applicability dates"

[6] *Id* at 5437 "Health Insurance Issuers"

[7] *Id* at 5417-18 "Overview of the Regulations: General Applicability Provisions" (see example in first column on 5418)

[8] *Id* at 5436 "Example 5"

simply states that "any condition defined by the plan as being or as not being a mental health or substance use disorder benefit must be defined to be consistent with generally recognized independent standards of current medical practice."[9]

Nicotine Dependence (ICD-9 305.10) is included in the DSM-IV, as is Nicotine Withdrawal (ICD-9 292) and Nicotine-Related Disorder Not Otherwise Specified (ICD-9 292.9). Therefore, if smoking cessation is covered by a health plan, as treatment for a substance use disorder the benefits would need to be compliant with MHPAEA.[iv]

13. How can one determine if a smoking benefit is offered within any of the 6 benefit classifications?

One should review the detailed benefit descriptions and exclusions from the summary plan documents (SPD), which represent the contracted benefits for each insured plan. Coverage for smoking cessation is typically addressed within the covered benefits sections of the SPD, and if coverage is not included, smoking cessation is typically found in the excluded conditions section of the SPD.

14. What if it is determined that there is a smoking cessation benefit in one of the 6 classifications?

MHPAEA requires that if a plan provides benefits for a mental health or substance use disorder in any classification it must provide benefits in all classifications for which medical/surgical benefits are provided and it must comply with the parity requirements in each classification.[10]

15. How does one determine the level of smoking cessation benefit for each of the benefit classifications?

Compliant benefit coverage is determined through the testing of financial requirements and quantitative and nonquantitative treatment limitations. The scope of services issues (how broad the coverage needs to be in each benefit classification) has not been addressed by the IFR and further guidance is needed to understand the extent of coverage required by MHPAEA within each classification.

16. How does one assess if a smoking cessation benefit design is compliant with MHPAEA?

Smoking cessation benefits covered within the insured benefit plan must comply with the provisions for financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations specified within MHPAEA.

The type and level of financial requirements for smoking cessation within each classification must satisfy the "substantially all" and "predominant" tests as described in MHPAEA. Nonquantitative treatment limitations such as step therapies or prior authorization requirements must be comparable to, and applied no more stringently than, those in place for substantially all medical/surgical benefits in that classification.[11]

17. What if only pregnant women are covered for a smoking cessation benefit?

The regulations do not specifically address this. However, they do require parity compliance by coverage unit including coverage for a single participant, for a participant plus spouse, for a family, etc. In other words, because coverage is provided for some women within the insured benefits, the regulations would likely require that all women, men, and children be covered as a result of the requirement to comply for each coverage unit.[12]

18. What if physicians and patients are surveyed on whether they offer or acquire advice on smoking cessation strategies, including medications?

The actions of insured members and their providers are not likely to be considered evidence of coverage. Proof of smoking cessation coverage is found in insured benefit plan documents.

19. What if telephone and/or online counseling services are offered for smokers trying to quit?

Telephone or online counseling services would be considered a form of wellness or EAP benefit, and likely to be outside the insured benefit coverage.

[9] *Id* at 5431 "Meaning of Terms: Substance use disorder benefits"

[10] *Id* at 5433 "General Parity Requirement"

[11] *Id*.

[12] *Id* at 5433 " Coverage Unit"

20. What if it is determined that there is no smoking cessation benefit in any of the 6 classifications?

It is likely then that nicotine addiction would be found to be a noncovered substance use disorder, which is allowed under MHPAEA. No specific mental health or substance use disorders are required to be included in insured health care benefits under MHPAEA.[13]

21. Can one drop smoking cessation benefit and be compliant with MHPAEA?

Yes, coverage for nicotine addiction is not required under MHPAEA. Plans can choose to remove such coverage at plan renewal, but must do so in such a way that they comply with MHPAEA (that is, removing coverage completely in every benefit classification).[14]

22. What should be considered when evaluating the option of providing smoking cessation benefits?

Federal mental health parity requirements apply to group health plans offering mental health or substance use disorder benefits. It does not require that applicable plans offer these benefits for any or all conditions. State law will continue to apply and may, for example, mandate certain mental health/substance use disorder coverage. There may be unintended cost consequences associated with removing coverage for mental health and substance abuse disorders.

[13] *Id* at 5431 "Meaning of Terms: Substance use disorder benefits"

[14] *Id* at 5437 "Scope"

Interpretation Questions

The following answers provided are based on the authors' interpretation of MHPAEA compliance requirements. You should seek your own counsel to determine whether your benefits are compliant with MHPAEA.

23. What are some examples of smoking cessation prescription drug coverage that may be affected by the implementation of the IFR?

Smoking cessation programs that include higher member cost-sharing than the "predominant" levels of medical/surgical drugs in the same formulary tier, either through deductibles, copays, or coinsurance, should be closely evaluated to determine whether these financial requirements comply with MHPAEA.

Programs with quantitative annual or lifetime treatment limits for smoking cessation drug coverage that do not have comparable treatment limits for substantially all medical/surgical drugs in the same formulary tier may need to reduce these smoking cessation drug coverage limits to comply with MHPAEA.

Any other nonquantitative treatment limitations for smoking cessation coverage of prescription drugs are also likely to constitute a risk for noncompliance if comparable nonquantitative treatment limitations do not exist for substantially all medical/surgical drugs on that tier. This includes processes such as required step therapies, prior authorization requirements, formulary placement or design processes, or other medical management criteria.[15]

24. What are some common quantitative and nonquantitative treatment limitations and financial requirements associated with smoking cessation prescription drug benefits that may be at risk for noncompliance?

If smoking cessation is covered in any of the other benefit classifications, and if coverage is provided for medical/surgical prescription drugs, then coverage must be provided for smoking cessation drugs. The coverage must comply with MHPAEA quantitative and nonquantitative treatment limitations and financial requirements.

a. Coverage of smoking cessation drugs within formulary tiers

The process used to guide formulary placement for substantially all medical/surgical drugs should also be applied to smoking cessation drugs.[16]

b. Coverage of over-the-counter (OTC) or generic drugs only

Covering only a limited number of brand drugs or excluding coverage of brand drugs for smoking cessation entirely may put the benefits at risk for a nonquantitative treatment limit violation if similar processes for brand limitation or exclusion do not exist for substantially all medical/surgical brand drugs.[17]

c. Prior authorization (PA) requiring enrollment in smoking cessation program

If substantially all medical/surgical drugs on the same formulary tier do not require comparable prior authorization, the benefits are at risk of having a nonquantitative treatment limitation that violates MHPAEA compliance requirements.[18]

d. Quantity limit (QL) allowing patients one quit attempt per year

If substantially all other medical/surgical prescription drugs on the same formulary tier do not have a comparable quantitative annual treatment limit, this may be a violation of the quantitative treatment limitations of MHPAEA.[19]

e. QL allowing patients 1 quit attempt per lifetime

[15] *Id* at 5433 "General Parity Requirement"

[16] *Id* at 5434 " Special Rule for Multi-Tiered Prescription Drug Benefits"

[17] *Id*.; *Id* at 5436 " Nonquantitative Treatment Limitations"

[18] *Id*.

[19] *Id*.

If substantially all other medical/surgical prescription drugs on the same formulary tier do not have a comparable quantitative lifetime treatment limit, this may be a violation of the quantitative treatment limitations of MHPAEA.[20]

f. Prescription drug cost share amounts that are not similar to other prescription drugs

If substantially all other medical/surgical prescription drugs on the same formulary tier do not have a comparable financial requirement, this may be in violation of the quantitative financial requirement of MHPAEA.[21]

g. Prescription drug reimbursement that occurs through submitting a receipt versus online adjudication

If substantially all other medical/surgical prescription drugs on the same formulary tier do not have a comparable processing requirement, this could be at risk for violation of the nonquantitative treatment limitations of MHPAEA.[22]

25. How does one evaluate smoking cessation prescription drug coverage to determine if it passes the "substantially all" and "predominant" tests?

Determining compliance is likely to include the development of an actuarial cost model with detailed costs by therapeutic drug category for all covered medical/surgical prescription drugs. Then each financial requirement, quantitative treatment limitation, or nonquantitative treatment limitation that exists for any smoking cessation drug on a tier is compared to the financial requirements or treatment limitations for all medical/surgical drugs on that tier.

For example, suppose a smoking cessation drug on Tier 2 has a 180-day quantity limit each year. In order to pass the "substantially all" test that would allow an annual quantity limit, the medical/surgical drugs that account at least two-thirds of all of the costs of medical/surgical drugs in Tier 2 would also have to have an annual quantity limit. To pass the "predominant" test that would allow the 180 day limit, medical/surgical drugs that account for more than 50% of the costs of medical/surgical drugs on Tier 2 would have to have a 180-day or lower annual quantity limit.

The same type of testing using the "substantially all" and "predominant" rules would apply to any financial requirements that exist on the smoking cessation drugs. This compliance testing is required for each tier that includes coverage of smoking cessation drugs.

26. What are some considerations around whether to purchase smoking cessation drugs as a prescription drug rider?

Providing coverage for smoking cessation through the purchase of a rider does not affect your need for compliance with MHPAEA requirements. All rider coverages must be combined with the base plan health care benefits for compliance determination.[23]

27. What are some considerations around whether to carve out mental health benefits?

Carving out mental health and substance use disorder benefits do not affect MHPAEA requirements. Carved-out benefits are subject to the same testing and compliance benefits as those that are not carved out.[24] Choosing to carve out behavioral benefits is a decision that should incorporate the pros and cons of managing benefits within the medical/surgical operations compared to contracting with an MBHO. These considerations should include both short-term and long-term analysis of financial, clinical, and operational factors. Also, carefully explore how a carve-out vendor will affect your ability to become and remain compliant with all of the non-quantitative treatment limitations that are included within the MHPAEA compliance requirements.

28. How can the incremental cost of expanded smoking cessation coverage be determined?

Plan sponsors can ask the health insurance company for rates associated with different smoking cessation benefit options. Alternatively, employers can seek guidance from their benefit consultants about the costs of benefit options available to them.

29. What are some ways to verify whether a smoking cessation benefit is compliant with MHPAEA?

If one is self-insured:

[20] *Id*.

[21] Id.

[22] *Id*.

[23] *Id* at 5417-18 "Overview of the Regulations: General Applicability Provisions" (see example in first column on 5418)

[24] *Id*

a. What services could a benefit consultant provide?

Informed employee benefits consultants can help you understand how MHPAEA affects you and your self-funded benefits. They may be able to help you complete detailed MHPAEA compliance testing or they may refer you to skilled and knowledgeable actuaries and lawyers to assist you with MHPAEA compliance.

b. What services could an actuary provide?

Informed and skilled actuaries can help you complete your MHPAEA compliance testing, including setting up the actuarial cost models, analysis of your detailed claims data, and review of detailed plan documents to complete all of the financial requirements and quantitative and nonquantitative treatment limitations compliance analysis. They can also complete a cost analysis of any required benefit changes that are necessary under MHPAEA and assist you in developing necessary filing materials for benefit plan and rate changes for the new plan year in states requiring such filing documents.

c. What services could a law firm provide?

An informed and skilled lawyer could review your detailed plan documents and provide an opinion on where you are at risk for MHPAEA noncompliance, including areas of the regulations that are unclear.

If one is fully insured:

a. What services could health plans provide?

You should be diligent in determining whether your health plan has completed all MHPAEA compliance testing for each of your benefit plans insured through them. You should understand the impact of benefit and rate changes that are due to MHPAEA compliance. Your health plan should also be compliant with all other communication requirements to you and your insured members including criteria for medical necessity determinations and reasons for any benefit denials.

b. What services could a benefit consultant provide?

Informed employee benefits consultants can help you understand how MHPAEA affects you and your insured benefits. They may be able to help you request documentation assuring compliance with MHPAEA from your health plan.

[i] Section 54.9812 (e) *Applicability* — (1) *Group health plans.* The requirements of this section apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits.

(2) *Health insurance issuers.* See 29 CFR 2590.712(e)(2) and 45 CFR 146.136(e)(2), under which a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits is subject to requirements similar to those applicable to group health plans under this section if the health insurance coverage is offered in connection with a group health plan subject to requirements under 29 CFR 2590.712 or 45 CFR 146.136 similar to those applicable to group health plans under this section.

Section 54.9812 (f) *Small employer exemption*—(1) *In general.* The requirements of this section do not apply to a group health plan for a plan year of a small employer. For purposes of this paragraph (f), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (or one in the case of an employer residing in a state that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

[ii] Section 54.9812 (e)(3) *Scope.* This section does not - (i) Require a group health plan to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan for one or more mental health conditions or substance use disorders does not require the plan under this section to provide benefits for any other mental health condition or substance use disorder;

Federal Register / Vol. 75, No. 21 / Tuesday, February 2, 2010 / Rules and Regulations, page 5413. If a plan provides benefits for a mental health condition or substance use disorder in one or more classifications but excludes benefits for that condition or disorder in a classification (such as outpatient, in-network) in which it provides medical/surgical benefits, the exclusion of benefits in that classification for a mental health condition or substance use disorder otherwise covered under the plan is a treatment limitation. It is a limit, at a minimum, on the type of setting or context in which treatment is offered.

[iii] Section 54.9812 *general.* Except as provided in paragraph (i)(2) of this section, the requirements of this section are applicable for plan years beginning on or after July 1, 2010. (2) *Special effective date for certain collectively-bargained plans.* For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan for plan years beginning before the later of either - (i) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008); or (ii) July 1, 2010.

[iv] Section 54.9812 (a) *Substance use disorder benefits* means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

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