The Mental Health Parity and Addiction Equity Act:

Key Elements and Implications for Smoking Cessation Therapies

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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.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was passed on October 3, 2008, and became effective for plan renewals for large insured groups (more than 50 employees, both fully insured and self-insured) on or after October 3, 2009. 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/substance abuse disorder coverage with medical /surgical coverage.

The Interim Final Rules (IFR) were issued on January 29, 2010 providing detailed regulations for MHPAEA and are effective for plan renewals on or after July 1, 2010 (or at the next contract period for collectively bargained contracts).[1] Although there are still some issues outstanding and some health plans are requesting a delay on final implementation, plan sponsors should be actively reviewing and modifying their benefit designs (if necessary) to comply with MHPAEA. Even prior to the publication of the IFR, the MHPAEA required good faith efforts at compliance. The cost of being found noncompliant with MHPAEA is up to $100 per covered member per day beginning with the first day that the benefits were to be compliant.

What Types of Plans Are Included in the Scope?

Health plans for large insured groups (those with more than 50 employees) are subject to MHPAEA even if the benefits are self-insured. In addition to employer-sponsored health plans, MHPAEA also applies to Medicaid managed care plans, SCHIP plans, and federal employee benefit plans. Nonfederal government employers that provide self-insured coverage may opt-out of MHPAEA compliance. MHPAEA does not apply to Medicaid fee-for-service nor does it apply to small group or individual health insurance.[2]

What Is Parity Compliance and How Is it Determined?

MHPAEA does not require the provision of insured health care benefits for any or all mental health or substance use disorders.[3] However, it does require that when these conditions are covered by a benefit plan, that benefits be provided at a level consistent with other medical/surgical conditions.

The IFR identifies 6 benefit classifications which comprise all medical/surgical benefits within a covered benefit plan: Inpatient In-Network, Inpatient Out-of-Network, Outpatient In-Network, Outpatient Out-of-Network, Emergency Care and Prescription Drugs. Some benefit plans may not provide coverage for all 6 benefit classifications. The IFR requires that any quantitative financial requirements (copayments, deductibles, coinsurance, etc.) and treatment limitations (calendar year limits, lifetime limits, quantity limits, etc.) for mental health and substance use disorder benefits must not be more restrictive than similar financial requirements or treatment limitations for medical/surgical benefits in each of these classifications.[4]

The rules describe 2 tests that must be completed to determine parity benefit compliance – the "Substantially All" test and the "Predominant" test. To include any financial requirement or treatment limitation on mental health or substance use disorder benefits, the requirement or limitation must apply to "substantially all" medical/surgical benefits in the tested benefit classification. "Substantially all" is determined as being at least two-thirds of all expected benefit plan payments. If "substantially all" medical/surgical benefits are subject to the tested financial requirement or treatment limitation, then that requirement or limitation can also be applied to mental health and substance use disorder benefits.[5]

The "Predominant" test is used to determine what level of financial requirement (dollar amount, percentage amount, etc.) or treatment limitation (visit limits, day limits, quantity limits, etc.) is permitted. The highest level allowed is determined to be the least restrictive level that applies to more than half of expected medical/surgical benefit payments in the tested classification.[6]

For example, if copayments are applied to at least two-thirds of the outpatient in-network services, copayments can be applied to mental health or substance use disorder benefits. If 45% of the outpatient in-network services are subject to $25 copayments and 35% of the outpatient in-network services are subject to $15 copayments, then the mental health and substance use disorder benefits must have a copayment at or below $15 to be in compliance with MHPAEA.

[1] 75 Federal Register 5410, 5437 "Effective/applicability dates"
[2] *Id.* at 5437 "Applicability"
[3] *Id* at 5437 "Scope"
[4] *Id* at 5432-33 "Parity Requirements with Respect to Financial Requirements and Treatment Limitations"
[5] *Id* at 5433-36 "Financial Requirements and Quantitative Treatment Limitations"
[6] *Id*.

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The portion of plan payments subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in a classification to be paid under the plan year. Any reasonable method may be used to determine the expected paid dollar amount under the plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation. Payment amounts should be measured before any financial requirements are imposed. Reasonable methods for determining the percentage of expected plan costs within each benefit classification are generally actuarial in nature and would be based on historical experience (if available), adjusted for any changes in benefit design, reimbursement, enrollment mix changes, etc.[7]

The IFR also requires that when coverage for mental health or substance use disorders is provided in any 1 of the 6 benefit classifications, then coverage must be provided in each of the 6 benefit classifications in which medical/surgical benefits are provided. If medical/surgical benefits are not provided in one of the benefit classifications (for example, outpatient out-of-network), mental health and substance abuse disorders do not need to be provided in the benefit classification.[8]

MHPAEA stipulates that any benefit covered under a rider must be considered along with other base benefit coverages when testing for benefit compliance. Benefits provided by an external mental health or substance use disorder vendor, such as a managed behavioral health care organization, must be combined with the base medical/surgical benefits in all parity testing.[9] Unlike riders, EAP benefits are not to be considered when testing for benefit compliance. However, it is prohibited to require full use of all available EAP visits before allowing insured outpatient benefit coverage to begin.[10]

What Scope of Services Is Required?

The IFR does not specify any minimum scope of services within the 6 benefit classes. MHPAEA only requires that mental health and substance abuse disorders be covered at a level consistent with medical/surgical benefits. In fact, the IFR does not define inpatient care, outpatient care or emergency care. The definition is left to the plan documents and must be consistent between the medical/surgical and mental health and substance abuse disorders.

What Are Nonquantitative Treatment Limitations?

Nonquantitative treatment limitations are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment, such as medical management standards, prescription drug formulary design, standards for provider admission to participate in a network, determination of usual, customary and reasonable amounts, requirements for using lower-cost therapies before a plan will cover more expensive therapies, conditional benefits on completion of a course of treatment, etc. The regulations require that any processes, strategies, evidentiary standards, or other factors used in applying nonquantitative treatment limitations to mental health and substance use disorder benefits **must be comparable to, and applied no more stringently than**, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits.[11]

What Conditions and Disorders Must Be Covered?

The MHPAEA does not require that any or all mental health or substance abuse disorders be covered. The IFR requires that the definition of the condition or disorder "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)."[12]

Implications for Smoking Cessation Programs and Benefits

Smoking cessation is covered under MHPAEA if it is considered a covered substance use disorder benefit under the health plan's provisions. Nicotine Dependence (ICD-9 305.10) is included in the DSM-IV, as is Nicotine Withdrawal (ICD-9 292) and Nicotine-Related Disorder NOS (ICD-9 292.9). Therefore, if it is covered by a health plan, it is very likely that smoking cessation benefits would fall within substance use disorder benefits, and then need to be compliant with MHPAEA.

If smoking cessation benefits are provided in any 1 of the 6 benefit classifications described in the IFR, then they must be provided in every other benefit classification that includes coverage for medical/surgical benefits. For example, if insured coverage is provided for outpatient counseling for smoking cessation, then coverage must also be provided for prescription drug treatments. Again, the IFR does not specify the scope of such prescription drug coverage, but only that the formulary construction, financial requirements, and treatment limitations be consistent with medications used to treat medical/surgical conditions.

The best source of information to determine if a health plan provides smoking cessation coverage is the detailed plan documentation. The plan documentation describes the plan's specific benefit coverage, including both covered and excluded treatments and conditions. The plan documentation will usually be explicit with respect to conditions and services that are excluded from coverage, as well as those that are covered.

Insured benefit coverage for smoking cessation must be changed, as necessary, to comply with the parity testing requirements. Any financial requirement for smoking cessation benefit coverage must be no more restrictive than those applied to substantially all benefits for medical/surgical conditions. For example, if smoking cessation counseling is

[7] *Id.*
[8] *Id* at 5433 "General Parity Requirement"
[9] Id at 5417-5418 "Overview of the Regulations: General Applicability Provisions"
[10] *Id* at 5436 "Example 5"
[11] *Id* at 5436 "Nonquantitative Treatment Limitations"
[12] *Id* at 5437 "Applicability"

covered within insured outpatient in-network benefits, copays could only be applied if substantially all outpatient in-network benefits for medical/surgical conditions had copay requirements. The level of the copay for smoking cessation counseling could then only be as high as the lowest copay within all copays that collectively apply to more than half of the medical/surgical outpatient in-network benefits. Similarly, copayments for covered prescription drugs must exist for substantially all medical/surgical drugs in the formulary tier being tested, and be at the same or lower level. Each formulary tier is tested separately.[13]

There are several ways that health plans could be found noncompliant with MHPAEA within their smoking cessation benefit coverage. The most common causes of noncompliance are tier placement and the use of prior authorization requirements. Placing single source brand smoking cessation drugs on a higher tier than substantially all medical/surgical drugs that are single source brands could put a plan at risk of a nonquantitative treatment limitation violation under MHPAEA. Covering only a limited number of brand drugs or excluding coverage of brand drugs for smoking cessation entirely may also put a plan 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 on the same tier.

The use of prior authorization requirements for smoking cessation prescription drug coverage puts a plan at risk for noncompliance if substantially all medical/surgical drugs on the same formulary tier as the covered smoking cessation drug do not require comparable prior authorization. An example of this would be requiring a member to be in counseling for their smoking cessation as a requirement to receiving coverage for smoking cessation prescription drugs.[14]

In summary, a health plan that has financial requirements (copays, coinsurance, etc.) or quantitative treatment limits (calendar year limits, lifetime limits, other quantity limits) for prescription drugs for smoking cessation is in violation of MHPAEA if substantially all other medical/surgical prescription drugs on the same formulary tier as the smoking cessation drug being tested do not have comparable financial requirements or treatment limits.

Action Suggested

Plan sponsors and their service providers and advisors need to be diligent when identifying and modifying insured benefits to be compliant with MHPAEA. For instance, it is easy to overlook smoking cessation benefits; they are covered by the act because they are a treatment for nicotine addiction, a substance abuse disorder. It can also be difficult to assess whether a smoking cessation benefit is offered in any of the benefit classifications. Consider a scenario where a health plan provides smoking cessation programs, a BHO manages smoking cessation counseling, and a PBM manages a rider for smoking cessation drugs – all benefits need to be combined in parity testing. Furthermore, compliance with the 'substantially all' test requires detailed attention because many of the financial requirements and treatment limitations for smoking cessation benefits are unique.

Some examples of smoking cessation financial requirements or treatment limitations that are unlikely to meet the 'substantially all' test include

1) Quantity limits that cap the number of quit attempts covered for a member by limiting the number of counseling visits or prescription drug prescriptions.
2) A requirement that a member enroll in a behavioral health counseling program to receive prescription drug coverage.
3) A prescription drug formulary for smoking cessation products that limits member options to OTC or generic drugs only yet provides brand drug options for other therapeutic classes.
4)

Although plans are not required to provide smoking cessation coverage, the incremental cost of modifying financial requirements or treatment limitations to be compliant are likely to be less than 1%. The short and long term costs from increased comorbid and attributable medical/surgical costs due to smoking may dwarf the cost of MHPAEA compliance.

Noncompliance with MHPAEA has the potential to be very expensive, which necessitates detailed attention by employers and insurers alike. The direct cost of being found noncompliant with MHPAEA is up to $100 per covered member per day beginning with the first day that the benefits were to be compliant. Compliance testing within insurers generally involves a combined effort of actuaries, lawyers and senior management. Compliance testing by employers usually involves HR directors, employee benefit consultants, lawyers and consulting actuaries.

[13] *Id* at 5433-36 "Financial Requirements and Quantitative Treatment Limitations"

[14] Id at 5436 "Nonquantitative Treatment Limitations"

Who Can Help?

An informed and skilled actuary can help you complete your MHPAEA compliance testing. The testing may include setting up the actuarial cost models, analyzing your detailed claims data, and reviewing detailed plan documents to assess the financial requirements and quantitative and nonquantitative treatment limitations for compliance. An actuary could also complete a cost analysis of any required benefit changes that are necessary under MHPAEA.

There is still uncertainty around some compliance details related to smoking cessation programs. The Departments responsible for implementation requested additional input from the industry on several topics, which may be a strong indication that additional official guidance or final rules will be forthcoming. In the interim, health plans should begin the necessary reviews that will allow them to comply with the spirit of the legislation and be prepared to document compliance with the MHPAEA as it is understood.

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