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

Steve Melek, FSA, MAAA
Anne Jackson, FSA, MAAA
Bruce Leavitt, MBA

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. It 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 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. They apply to collectively bargained contracts after the end of their current contract period if after July 1, 2010.[1] The Act also applies to Medicaid managed care plans, SCHIP plans, and federal employee benefit plans. It does not apply to Medicaid fee-for-service. Non-federal government employers that provide self-insured coverage may opt-out of MHPAEA compliance. The cost of being found noncompliant with MHPAEA is up to $100 per covered member beginning with the first day that the benefit was to be compliant.[2]

What Is Parity Compliance and How Is It Determined?

For those insured benefits affected by MHPAEA, the act does not require the provision of benefits for all mental health or substance use disorders.[3] However, it does require that when benefits for any of these disorders are covered that it be done at a level equitable with other health conditions. To be equitable, the IFR requires that when coverage occurs in at least one of 6 benefit classifications – inpatient (both in and out of network), outpatient (both in and out of network), emergency care and prescription drugs – that coverage must be provided for all of the classifications.[4] Furthermore, it stipulates that any benefit covered under a rider must be considered along with other base benefit coverages when testing for 6-benefit compliance.[5] Unlike riders, EAP benefits are not included in the testing for benefit compliance. However, it is prohibited to require full use of all EAP visits before allowing insured outpatient benefit coverage to begin.[6]

Although the IFR does not address the scope of services required to be compliant within or across the 6 benefit classifications, it does provide a 'substantially all' means test to apply to financial requirements and treatment limitations. The IFR requires that the financial requirements and treatment limits that are applied to mental health disorders and substance abuse be at a level similar to 'substantially all' medical/surgical benefits, and that this test be met for each of the benefit classifications. Furthermore, the IFR specifically prohibits financial requirements (eg, co-pays, coinsurance, deductibles), quantitative treatment limitations (eg, calendar year limits, quantity limits, lifetime limits), and nonquantitative treatment limitations (eg, medical management standards, prior authorization requirements, formulary placement criteria, step therapies) be imposed on mental health and substance use disorder benefits that are not similar to what is applied to 'substantially all' medical/surgical benefits in each benefit classification.[7]

Actions to Consider

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 use disorder. It can also be difficult to assess whether a smoking cessation benefit is

[1] 75 Federal Register 5410, 5437 "Effective/Applicability Dates"

[2] *Id* at 5437 "Applicability"

[3] *Id* at 5437 "Scope"

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

[5] *Id* at 5417-18 "Overview of the Regulations: General Applicability Provisions"

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

[7] *Id* at 5432-33 "Parity Requirements with Respect to Financial Requirements and Treatment Limitations"

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offered in any of the 6 benefit classifications. For example, a scenario where a health plan provides smoking cessation programs, a Behavioral Health Organization manages smoking cessation counseling, and a Pharmacy Benefit Manager provides a rider for smoking cessation drugs is quite complex. Furthermore, compliance with the 'substantially all' test requires attention because many of the financial requirements and treatment limitations for smoking cessation benefits are unique.

Some examples of distinct 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.

Steve Melek is a principal and consulting actuary with the Denver office of Milliman. Contact Steve at steve.melek@milliman.com or 303.299.9400.
Anne Jackson is a principal and consulting actuary with the Indianapolis office of Milliman. Contact Anne at anne.jackson@milliman.com or 317.639.1000.
Bruce Leavitt is a consultant with the Indianapolis office of Milliman. Contact Bruce at bruce.leavitt@milliman.com or 317.639.1000.