The Mental Health Parity and Addiction Equity Act and the Affordable Care Act: Implications for Coverage of Tobacco Cessation Benefits

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")¹ is a federal law that establishes parity requirements for insurance coverage of mental health conditions and substance use disorders. This federal law prohibits some insurance plans² from charging higher deductibles or co-payments or limiting the number or frequency of provider visits for mental health or substance use disorder treatment unless – and to the same extent that – those limitations are also imposed on medical/surgical benefits. The MHPAEA was extended by the Affordable Care Act ("ACA")³ in 2010. As a result, coverage of mental health conditions and substance use disorders will become mandatory for most insurance providers by 2014.

This fact sheet is designed to answer some of the most frequently asked questions about the MHPAEA, and how it has been modified by the ACA. Specifically, it addresses the implications of these federal laws on insurance coverage for one type of substance use disorder benefits: tobacco cessation benefits.

Q: What does the MHPAEA require?

A: In short, the MHPAEA requires parity in coverage of mental health ("MH") benefits and substance use disorder ("SUD") benefits in relation to medical/surgical ("M/S") benefits. For those insurers who elect to cover mental health conditions and substance use disorders, any financial requirements and treatment limitations placed on MH and SUD benefits must be equal to those placed on M/S benefits.

Specifically, regulations promulgated under the MHPAEA require that covered health plans that offer benefits for a specific MH condition or SUD in any one of six classifications (inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs) also provide benefits for that MH condition or SUD in every other classification in which M/S benefits are offered.⁴ For example, if a plan provides prescription drug coverage for treatment of nicotine dependence and for outpatient, in-network visits for any medical or surgical condition, then it must provide coverage for outpatient, in-network visits related to
nicotine dependence at levels no more restrictive than those provided for other medical visits.5

**Q: What types of financial requirements are governed by the MHPAEA?**

**A:** Under the MHPAEA, any limitations on deductibles, co-payments, co-insurance, and out-of-pocket maximums6 that are placed on MH and SUD benefits must be the same as those placed on M/S benefits.

**Q: What types of treatment limitations are governed by the MHPAEA?**

**A:** The law requires that any quantitative treatment limits on annual, episode, and lifetime visits7 that are placed on MH and SUD benefits must be equal to those placed on M/S benefits. The MHPAEA also covers non-quantitative treatment limitations, such as: “medical management” standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; formulary design for prescription drugs; standards for provider admission to participate in a network, including reimbursement rates; plan methods for determining usual, customary, and reasonable charges; refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “step therapy” protocols); and plan exclusions based on failure to complete a course of treatment.8

**Q: To whom does the MHPAEA apply?**

**A:** The MHPAEA and its implementing regulations apply to all group health plans sponsored by private and public sector employers with more than 50 employees that offer M/S benefits and MH or SUD benefits (or both).9 It also applies to health insurance issuers who sell coverage to employers with more than 50 employees.

Group health plans for employers with 50 or fewer employees are exempt from the MHPAEA.10 An exemption may also be granted to any plan where the parity requirements would increase the total cost of coverage under the plan by 2% in the first year11 and 1% in all subsequent years.12 In order to qualify for this exemption, the plan must (1) have implemented the requirements of the MHPAEA for at least six months before seeking an exemption; (2) have an actuary certify that the actual total costs for the current plan year increased by the specified percentage; and (3) file an exemption request with the Secretary of the Department of Labor.

**Note:** The MHPAEA itself does not require group health plans to provide MH or SUD benefits; it merely requires that if plans elect to offer such benefits, then they must provide them under conditions that are substantially equivalent to those imposed on M/S benefits. However, the Affordable Care Act, which extends the MHPAEA’s requirements, will require qualified health plans to cover mental health and substance use conditions as part of an “essential health benefits” package beginning in 2014, as explained below.
Q: How is MHPAEA enforced?

A: The Department of Labor and the Internal Revenue Service generally have enforcement authority over private sector employment-based plans that are subject to ERISA. The U.S. Department of Health and Human Services (“HHS”) has direct enforcement authority over self-funded, non-federal governmental plans. While state insurance commissioners have primary authority over issuers in the large group market, HHS has secondary enforcement authority.

Q: Does MHPAEA require plans to offer Substance Use Disorder (SUD) benefits?

A: No. The MHPAEA does not require a plan to offer SUD benefits, nor is a plan obligated to offer benefits for any particular SUD even if the plan offers benefits for some SUDs.

Q: What effect does the MHPAEA have on tobacco cessation benefits?

A: Under the regulations governing the MHPAEA, a plan is allowed to determine which SUDs are covered under the plan as long as the plan complies with state and federal laws and is consistent with generally recognized independent standards of current medical practice. The regulations specifically refer to the Diagnostic and Statistical Manual of Mental Disorders (“DSM-IV”), the International Classification of Diseases Manual, and state law as acceptable sources of information in determining what qualifies as a MH or SUD. Nicotine Dependence is listed as a mental health diagnosis in the DSM-IV, as is Nicotine Withdrawal and Nicotine-Related Disorder Not Otherwise Specified (NOS). In addition, state health parity acts may specifically list nicotine dependence as a covered condition.

Since nicotine dependence is defined as a psychological disorder in the DSM-IV and is generally recognized by current medical practice as a substance use disorder, if a group health plan provides tobacco cessation benefits, those benefits are subject to the MHPAEA’s parity requirements and must be provided subject to terms and conditions substantially equivalent to those imposed on medical/surgical benefits. That said, federal law does not currently require coverage of tobacco cessation treatment.

Q: How does the Affordable Care Act interact with the MHPAEA?

A: The Affordable Care Act (“ACA”) extends the MHPAEA to require provision of MH and SUD benefits at parity with M/S benefits to most previously-uninsured people who will gain insurance under the new law. Specifically, the ACA mandates that all qualified health plans provide an “essential health benefits” package, which must include MH and SUD services including behavioral health treatment. It also mandates that a health insurance issuer that offers health insurance coverage in the individual or small group market provide an essential health benefits package. Further, the ACA prohibits insurers from refusing to cover people with a history of mental illness or substance abuse,
or from charging higher premiums based on having such a history. All plans offered through the new health insurance exchanges will be required to comply with the MHPAEA’s provisions. Beginning on January 1, 2014, the Federal Employee Health Benefits Plan, all state employee health plans, and health maintenance organizations (“HMOs”) will be subject to these requirements.  

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Notes


2. Generally speaking, the MHPAEA applies to group health plans that offer both medical/surgical benefits and mental health benefits, and/or medical/surgical benefits and substance use disorder benefits.


6. 26 C.F.R. § 54.9812-1T(c)(1)(ii).

7. 26 C.F.R. § 54.9812-1T(c)(1)(ii).

8. 26 C.F.R. § 54.9812-1T(c)(4)(ii).

9. 26 C.F.R. § 54.9812-1T(e)(1).


15. 26 C.F.R. § 54.9812-1T(a).

16. Id.


21. 42 U.S.C. § 1396u-7(b)(5).