Tobacco Control Legal Consortium

Fact Sheet

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

Two federal laws expand health insurance coverage for substance use disorders: the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)[1] and the Affordable Care Act (ACA).[2] Treatment for substance use disorders can include tobacco cessation. The MHPAEA is a 2008 federal law requiring that insurance coverage of mental health conditions and substance use disorders be comparable to coverage of other medical conditions. The ACA requires that most new insurance plans provide some coverage for mental health and substance use disorder services as of 2014 and these services must be provided in compliance with the MHPAEA's requirements.

This fact sheet answers some of the most frequently asked questions about how the MHPAEA and the ACA affect insurance coverage of tobacco cessation benefits as a type of substance use disorder. For more information on the ACA's impact on tobacco, including coverage for tobacco cessation, see the Consortium's fact sheet, *How the Affordable Care Act Affects Tobacco Use and Control*.

Q: What do the MHPAEA and the ACA require with regard to substance use disorder benefits?[3]

A: The MHPAEA requires coverage of mental health benefits and substance use disorder ("SUD") benefits to be similar to medical/surgical benefits. For those insurers who choose to cover mental health conditions and substance use disorders, any *financial requirements* and *treatment limitations* placed on mental health and SUD benefits must be equal to those placed on medical/surgical benefits.

For example, the MHPAEA prohibits covered insurance plans 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 ACA requires coverage for "mental health and substance use disorder services, including behavioral health treatment" as part of the package of "essential health benefits."[4] In order to satisfy the "essential health benefits" standard, the mental health and SUD services must be

provided in compliance with the MHPAEA and its implementing regulations.[5] However, the scope of coverage for specific mental health and substance use disorders is likely to vary by state and by insurance provider, just as it does for coverage of medical/surgical benefits.

Q: Does federal law require plans to offer SUD benefits?

A: It depends. The MHPAEA does not require a plan to offer SUD benefits, nor is a plan obligated to offer benefits for any particular SUD, such as nicotine addiction, even if the plan offers benefits for some SUDs.[6] The ACA requires covered insurance plans to provide mental health and SUD benefits. However, even under the ACA, individual insurance companies may decide not to provide coverage for the treatment of particular substance use disorders, such as tobacco or nicotine dependence.[7] Federal law only requires that if SUD benefits are offered that they be comparable to medical and surgical benefits.

Q: What is the cost for SUD benefits?

A: Under the MHPAEA, any limitations on deductibles, co-payments, co-insurance, and out-of pocket maximums that are placed on mental health and SUD benefits must be the same as those placed on medical/surgical benefits.[8]

Under the ACA, if tobacco cessation services are accessed as a "preventive service," there is no co-pay allowed.[9] If treatment for tobacco dependence is provided as a SUD benefit, the MHPAEA limitations on deductibles, co-payments, etc. apply.

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

A: Under the regulations that apply to 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.[10] The regulations specifically refer to the current versions of the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), the International Classification of Diseases, and state law as acceptable sources of information in determining what qualifies as a mental health or SUD.[11] The DSM-5 lists Tobacco Use Disorder, Tobacco Withdrawal, and Unspecified Tobacco-Related Disorder as mental health diagnoses.[12] In addition, state health parity acts may specifically list tobacco or nicotine dependence as a covered condition.[13]

Since tobacco use is defined as a SUD in the DSM-5 and is generally recognized by current medical practice as a SUD, if a group health plan provides treatment for tobacco use as a SUD, 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. However, the MHPAEA does not require insurance plans to provide coverage for particular SUDs, such as tobacco use. The law 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 medical/surgical benefits.

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

A: The ACA potentially expands coverage for tobacco cessation in two ways:

1) by requiring coverage for tobacco cessation as a "preventive and wellness service" as part of the required "essential health benefits" package[14] (for additional information on the scope of tobacco cessation coverage as a preventive service, see the Consortium's fact sheet on "How the Affordable Care Act Impacts Tobacco Use and Control"); and
2) by requiring coverage for mental health and SUD benefits, including behavioral health treatment, as part of the "essential health benefits" package, which *could* extend to tobacco cessation treatment.[15]

As a practical matter, most people seeking tobacco use treatment will likely access cessation services as a "preventive service," because there will be no cost to the patient. However, it is also possible that tobacco dependence could be treated as a SUD. In that case, the MHPAEA rules will apply.

Under the ACA, additional types of insurance plans will now be required to provide mental health and SUD services as part of the "essential health benefits." If mental health and SUD services are provided, the ACA requires that these benefits be provided on fair and equal terms as with medical/surgical benefits as with medical/surgical benefits in compliance with MHPAEA. 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.

Q: What insurance plans are subject to the MHPAEA and the ACA's requirements?

A: When first adopted in 2008, the MHPAEA primarily applied to employer-based health insurance plans (also known as group health plans) with more than 50 employees. The ACA extends the MPHAEA's requirements to additional types of insurance plans. Note that not every type of plan is listed below; if you have a question about a particular kind of insurance plan, please consult information available from the Department of Labor.[16] As of January 1, 2014, the MHPAEA applies to:

- Large group health plans sponsored by private and public sector employers with more than 50 employees that offer medical/surgical benefits and mental health or SUD benefits (or both)[17]
- Health plans offered to individuals[18]
- All plans offered through the ACA's health insurance exchanges or marketplaces[19]
- Medicaid managed care organizations and Medicaid Alternative Benefit Plans (including benchmark and benchmark-equivalent plans for individuals qualifying for Medicaid expansion)[20]
- Children's Health Insurance Program (CHIP)[21]

The MHPAEA does *not* apply to:

- Small group health plans (50 or fewer employees)[22] – however, these plans still must

provide the "essential health benefits" required by the ACA, which include mental health and SUD treatment, and these services must be provided in compliance with the MHPAEA[23]
- Small group plans created before March 23, 2010 (these plans are "grandfathered" under the ACA)[24]
- Retiree-only health plans[25]
- Medicare[26]
- Traditional Medicaid[27]
- Non-federally administered self-insured government health plans that choose to opt out of the MHPAEA[28]

An exemption to the MHPAEA also may be granted to any plan where the parity requirements would increase the total cost of coverage under the plan by 2% in the first year and 1% in all following years.[29] To qualify for this exemption, the employer 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.

Q: Who enforces the MHPAEA?

A: The U.S. Departments of Labor and the Treasury generally have enforcement authority over private, employment-based group health plans. The U.S. Department of Health and Human Services ("HHS") has direct enforcement authority over non-federal governmental plans, such as those sponsored by state and local government employers. While state insurance commissioners have primary authority over health insurance issuers, HHS has secondary enforcement authority.[30] Employees with questions about MHPAEA compliance may contact the Department of Labor (DOL) at www.askebsa.dol.gov or 1-866-444-3272. The DOL will work with the other federal departments and the states, as appropriate, to address MHPAEA violations.[31]

Last updated: March 2014

Notes

[1] Pub. L. No. 110-343, 122 Stat. 3765, H.R. 1424, 110th Cong. (2008) (amending 29 U.S.C. 1185a (ERISA); 42 U.S.C. 300gg–5 (Public Health Service Act); and 26 U.S.C. § 9812 (Internal Revenue Code)), *available at* https://www.cms.gov/HealthInsReformforConsume/Downloads/MHPAEA.pdf. For an overview of the MHPAEA, see National Health Law Program, *Issue Brief: Mental Health Parity and Addiction Equity Act of 2008: Final Regulations and Federal Guidance* (Jan. 2014), *available at* http://www.healthlaw.org/publications/browse-all-publications/issue-brief-mhpaea2008#.UvLF7_tL1aS.

[2] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) was amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Together, the two laws are known as the Affordable Care Act (ACA).

[3] For additional background on this topic, see The Network for Public Health Law, *Applicability of Patient Protection and Affordable Care Act to Substance Use Disorder Treatment* (Oct. 2011), *available at* https://www.networkforphl.org/_asset/18h1yj/ACA-and-SUD-TreatmentFINAL2.pdf.

[4] 42 U.S.C. § 18021(a)(1)(B); 42 U.S.C. § 18022(b)(1)(I); 42 U.S.C. § 300gg-6(a).
[5] 45 C.F.R. § 156.115(a)(3).
[6] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 682 (Nov. 13, 2013), *available at* https://www.federalregister.gov/articles/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act; 26 C.F.R. § 54.9812-1(e)(3)(i); 29 C.F.R. § 2590.712(e)(3)(i); 45 C.F.R. § 146.136(e)(3)(i).
[7] 26 C.F.R. § 54.9812-1(e)(3)(ii); 29 C.F.R. § 2590.712(e)(3)(ii); 45 C.F.R. § 146.136(e)(3)(ii).
[8] 26 C.F.R. § 54.9812-1(c)(1)(ii); 29 C.F.R. § 2590.712(c)(1)(ii); 45 C.F.R. § 146.136(c)(1)(ii).
[9] 42 U.S.C.A. § 300gg-13.
[10] 26 C.F.R. § 54.9812-1(a); 29 C.F.R. § 2590.712(a); 45 C.F.R. § 146.136(a).
[11] *Id.*
[12] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 305.1, 292.0, 292.9 (5th ed. 2013). Tobacco is also listed as a type of Substance/Medication-Induced Sleep Disorder.
[13] *See* National Conference of State Legislatures, *State Laws Mandating or Regulating Mental Health Parity* (Jan. 2014), *available at* http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx.
[14] 42 U.S.C. § 18021(a)(1); 42 U.S.C. § 18021(b)(1)(I); 42 U.S.C. § 300gg-6(a).
[15] 42 U.S.C. § 18021(b)(1)(E).
[16] U.S. DEP'T OF LABOR, MENTAL HEALTH PARITY, *available at* http://www.dol.gov/ebsa/mentalhealthparity/.
[17] 45 C.F.R. § 146.136; see also SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Mental Health Parity and Addiction Equity* (last updated 1/10/14), *available at* http://beta.samhsa.gov/health-reform/parity. With regards to parity, a small group plan is defined as an employment-based plan that includes no more than 50 employees. A large group plan is an employment-based plan that includes 51 or more employees. An individual plan is one that someone purchases directly from an insurance company, and is not employment-based.
[18] U.S. DEP'T OF HEALTH & HUMAN SERVICES, ASPE Research Brief, *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*, (Feb. 2013), *available at* http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf.
[19] 42 U.S.C.A. § 18031(j).
[20] CENTERS FOR MEDICARE AND MEDICAID SERVICES, Letter to State Medicaid Directors Re: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans (Jan. 16, 2013), *available at* http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.
[21] *Id.*
[22] U.S. DEP'T OF LABOR, *FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation*, Q8, *available at* http://www.dol.gov/ebsa/faqs/faq-aca5.html.
[23] 42 U.S.C.A. § 300gg-26; 45 C.F.R. § 146.136. *See also* U.S. DEP'T OF LABOR, *FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation*, *available at* http://www.dol.gov/ebsa/faqs/faq-aca17.html.
[24] U.S. DEP'T OF HEALTH & HUMAN SERVICES, ASPE Research Brief, *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*, February 2013, *available at* http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf; *see also* SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Mental Health Parity and Addiction Equity* (last updated 1/10/14), *available at* http://beta.samhsa.gov/health-reform/parity.

Grandfathered plans are plans that existed when the ACA was adopted and have not been changed in certain specified ways.

[25] U.S. DEP'T OF LABOR, *Frequently Asked Questions for Employees about the Mental Health Parity and Addiction Equity Act*, *available at* http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.

[26] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Mental Health Parity and Addiction Equity* (last updated 1/10/14), *available at* http://beta.samhsa.gov/health-reform/parity.

[27] *Id.*

[28] CENTERS FOR MEDICARE AND MEDICAID SERVICES, *The Mental Health Parity and Addiction Equity Act*, *available at* http://cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

[29] 29 U.S.C. § 1185a(c)(2); 26 C.F.R. § 54.9812-1(g), 29 C.F.R. § 2590.712(g), 45 C.F.R. § 146.136(g).

[30] U.S. DEP'T OF LABOR, *FAQs on Understanding Implementation of The Mental Health Parity and Addiction Equity Act of 2008*, *available at* http://www.dol.gov/ebsa/faqs/faq-mhpaeaimplementation.html; *see also* 78 Fed. Reg. 68252.

[31] U.S. DEP'T OF LABOR, *Frequently Asked Questions for Employees about the Mental Health Parity and Addiction Equity Act*, *available at* http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.