



December 10, 2010

National Health Law Program
North Carolina Office
101 East Weaver Street, Suite G-7
Carrboro, NC 27510

Dear National Health Law Program:

Thank you for giving us the opportunity to comment on issues related to the Mental Health Parity and Addiction Equity Act (“MHPAEA”) and its treatment of tobacco cessation services, as they may relate to cessation coverage questions in Arkansas. As you know, the Tobacco Control Legal Consortium does not provide legal representation or advice and is not authorized to practice law in Arkansas. That said, we are pleased to offer our comments and observations, in partnership with the Public Health Law Network, based on our experiences with tobacco control laws and policies in other states.

The issue presented is whether the MHPAEA: (1) imposes an obligation upon covered insurers to provide tobacco cessation coverage; and (2) even if no such obligation exists under federal law, if a covered insurer voluntarily opts to provide tobacco cessation services, does that action trigger a duty to provide other types of substance use disorder benefits under the MHPAEA.

Overview of the Mental Health Parity and Addiction Equity Act

The Mental Health Parity Act of 1996 (“MHPA”)¹ established that a group health plan may not impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.² The MHPA specifically excluded chemical dependency or substance use disorder benefits. Subsequently, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)³ was passed to extend the MHPA’s parity provisions to substance use disorder, as well as mental health, benefits. The MHPAEA also goes further than the MHPA did with regard to coverage for mental health conditions; the MHPA banned plans from setting lower annual and lifetime spending limits for mental health treatments, while the MHPAEA builds on those protections by banning differences in co-payments, deductibles, and treatment limitations.

¹ 29 U.S.C. § 1185a.

² U.S. Dep’t of Labor, Mental Health Parity Act (MHPA) Factsheet (Oct. 2008), *available at* <http://www.dol.gov/ebsa/newsroom/fsmhparity.html>.

³ H.R. 1424, 110th Cong. (2008) (enacted; amending 29 U.S.C. 1185a, § 712 (ERISA); 42 U.S.C. 300gg–5, § 2705 (Public Health Service Act); and I.R.C. § 9812 (Internal Revenue Code)); *available at* <https://www.cms.gov/HealthInsReformforConsume/Downloads/MHPAEA.pdf>.

The MHPAEA preserves the MHPA's insurance coverage protections for mental health conditions, and adds significant new coverage protections for both mental health and substance use disorders. However, although the law requires equivalence with regard to annual and lifetime dollar limits, financial requirements, and treatment limitations for mental health ("MH") and substance use disorder ("SUD") coverage *if* an insurer opts to provide such coverage, the MHPAEA *does not require* large group health plans and their health insurance issuers to include MH or SUD benefits in their benefits packages.⁴ The law's parity requirements apply only to large group health plans and their health insurance issuers that already include MH/SUD benefits in their benefit packages.

MHPAEA Requirements

In sum, the MHPAEA creates the following changes for group health plans and insurance issuers that already provide mental health and/or substance use disorder benefits.

- If a group health plan includes both medical/surgical benefits and MH benefits, then:
 - the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to MH benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
 - if the plan provides for out-of-network medical/surgical benefits, then it must also provide for out-of-network MH benefits; and
 - MH benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits.
- Similarly, if a group health plan includes both medical/surgical benefits and SUD benefits, then:
 - the financial requirements and treatment limitations that apply to SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
 - if the plan provides for out-of-network medical/surgical benefits, then it must also provide for out-of-network SUD benefits; and
 - SUD benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits.⁵

In addition, the MHPAEA requires that the standards for medical necessity determinations and the reasons for any denial of benefits relating to mental health conditions or substance use disorders must be disclosed upon request. Finally, the MHPAEA continues the MHPA's parity requirements regarding annual and lifetime dollar limits for mental health conditions and extends these requirements to substance use disorder benefits.

⁴ U.S. Dep't of Labor, Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Factsheet (Jan. 2010), available at <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

⁵ *Id.*

Generally, the MHPAEA is effective for plan years beginning on or after October 3, 2009. For most calendar year plans, the effective date will be January 1, 2010. There is a delayed effective date for group health plans maintained pursuant to a collective bargaining agreement. The Departments of Health and Human Services (“HHS”), Labor (“DOL”), and the Treasury published an interim final rule implementing the provisions of MHPAEA on February 2, 2010.⁶ The regulation is effective on April 5, 2010, and applicable to plan years beginning on or after July 1, 2010.

MHPAEA Applicability, Exemptions, and Enforcement

The MHPAEA applies to group health plans sponsored by private and public sector employers with more than 50 employees, including self-insured and fully insured arrangements. The Act also applies to health insurance issuers who sell coverage to employers with more than 50 employees. The MHPAEA does *not* apply to issuers who sell health insurance policies to employers with 50 or fewer employees or who sell health insurance policies to individuals.

As noted above, the MHPAEA’s parity provisions contain an exemption for certain small employers (those that employed at least two employees but no more than 50 employees during the preceding calendar year). In addition, the MHPAEA allows a plan to seek an exemption from its requirements if, as a result of providing MH/SUD coverage, the cost of coverage with respect to medical/surgical benefits and MH/SUD disorder benefits rises more than a specified percentage (2% in the first year and 1% annually thereafter). In order to qualify for this exemption, the plan must: (1) have implemented the requirements of the MHPAEA for at least 6 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. The exemption applies for one plan year, so a plan seeking a long-term exemption would have to reapply on an annual basis.

The DOL and the Internal Revenue Service (“IRS”) generally have enforcement authority over private sector employment-based plans that are subject to the federal Employee Retirement Income Security Act (ERISA).⁷ HHS has direct enforcement authority with respect to 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.

Coverage of Tobacco Cessation Benefits under the MHPAEA

Providing one or more mental health or substance use disorder benefits does not obligate a plan to offer benefits for any other MH condition or SUD under the MHPAEA. The Act’s interim final rules simply require that if a health plan offers MH or SUD benefits for a specific

⁶ *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, 75 Fed. Reg. 5410 (Feb. 2, 2010) (to be codified at 45 CFR pt. 146), available at <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>.

⁷ 29 U.S.C. § 1001 *et seq.* ERISA is a federal law which, generally speaking, sets minimum standards for most voluntarily established, private industry pension and health plans to provide protection for individuals in these plans. Section 514 of ERISA (now codified at 29 U.S.C. § 1144) preempts all state laws that “relate to any employee benefit plan,” with certain enumerated exceptions.

condition 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), then benefits must be provided for that condition in every classification in which medical/surgical benefits are offered.⁸

Smoking cessation is covered under MHPAEA if it is considered treatment for a covered substance use disorder under an applicable health plan's provisions. The MHPAEA does not specify or limit which mental health or substance use disorder conditions are covered by its provisions. The interim final rules simply state 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 The rules define substance use disorder benefits as "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."¹⁰

As noted above, the MHPAEA's implementing regulations state that "[a]ny 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."¹¹ The Act cites the most current versions of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-IV"), the International Classification of Diseases Manual ("ICD-10"), and state law as acceptable sources of information in determining what qualifies as a substance use disorder. Nicotine Dependence is listed as a mental health diagnosis in the DSM-IV,¹² as is Nicotine Withdrawal and Nicotine-Related Disorder Not Otherwise Specified (NOS). Therefore, if smoking cessation is covered by a health plan subject to the MHPAEA as treatment for a substance use disorder, then the cessation benefits would need to be provided in compliance with the MHPAEA's parity provisions.

Since nicotine dependence is defined as a psychological disorder in the DSM and is generally recognized by current medical practice as a substance use disorder, if a group health plan already provided tobacco cessation benefits, such benefits are going to be subject to the MHPAEA's parity requirements. However, as noted above, the MHPAEA does not require that plans provide mental health or substance use disorder coverage; nor does it require that plans cover any specific type of MH/SUD treatment. Therefore, if a group health plan did *not* provide tobacco cessation benefits prior to the effective date of the MHPAEA, the Act does not mandate that the plan now provide such benefits. It merely requires that group health plans that already provided tobacco cessation benefits continue to provide them, and to do so in compliance with the Act's parity requirements.

⁸ *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, 75 Fed. Reg. 5410, 5432-33 (Feb. 2, 2010).

⁹ *Id.* at 5431.

¹⁰ *Id.* at 5440.

¹¹ *Id.* at 5445.

¹² AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (2000) ("DSM-IV"), 305.10.

In sum, group health plans do not have to provide coverage for every mental health condition or substance use disorder under the MHPAEA. Plans subject to the MHPAEA may define both mental health and substance use disorder benefits in their plan documents in a limiting fashion. Further, plan sponsors may maintain medical management and utilization review requirements. However, plans may be subject to additional requirements under *state* law. Plans are also subject to applicable state coverage laws, which may impose more stringent coverage requirements, as long as they require parity to at least the same level as the MHPAEA.

Arkansas Mental Health Parity Act of 2009

In addition to the MHPAEA, almost all states have corresponding mental health/substance use disorder parity or mandate acts. There is no general consensus on the extent of state law-required insurance coverage for mental health conditions and substance use disorders. Forty nine (49) states and the District of Columbia currently have some type of health parity law, but these laws vary considerably.¹³ Generally speaking, these types of laws can be divided into three categories:

- (1) mental health/substance use disorder parity or “equal coverage” laws;
- (2) minimum mandated mental health/substance use disorder benefit laws;¹⁴ and
- (3) mental health/substance use disorder “mandated offering” laws.¹⁵

Arkansas has one of the broader state health parity acts in that it requires parity in coverage of all mental illnesses and substance abuse disorders. The Arkansas Act was amended in 2009 in order to bring it into line with the MHPAEA. It provides: “It is the intent of this state that *if* a health benefit plan provides insurance coverage for a mental illness or substance abuse disorder, the treatment of the mental illness or substance abuse disorder shall be as available as and at parity with that for other medical illnesses.”¹⁶ The Arkansas Mental Health Parity Act of 2009 specifically defines “mental illnesses” and “substance use disorders” as “those illnesses and disorders that are covered by a health benefit plan listed in the International Classification of

¹³ National Conference of State Legislatures (NCSL), State Laws Mandating or Regulating Mental Health Benefits (Feb. 2009, updated Feb. 2010), <http://www.ncsl.org/IssuesResearch/Health/StateLawsMandatingorRegulatingMentalHealthB/tabid/14352/Default.aspx> (last visited Oct. 22, 2010).

¹⁴ “Minimum mandated benefit laws” are defined as (state) laws that require that some level of coverage be provided for mental illness, serious mental illness, substance abuse, or a combination thereof. These laws are not considered full parity laws because they allow discrepancies in the level of benefits provided between mental illnesses/substance use disorders and physical illnesses. For instance, these laws permit discrepancies in the form of different visit limits, copayments, deductibles, and annual and lifetime limits. *Id.*

¹⁵ “Mandated offering laws” are (state) laws that do not require that mental health or substance use disorder benefits be offered at all, but provide some level of optional coverage. Generally, a mandated offering law operates in one of two ways. First, it can require that an option of coverage for mental illness, serious mental illness, substance abuse, or a combination thereof, be provided to the insured. This option of coverage can be accepted or rejected by the insured and, if accepted, will usually require an additional or higher premium. Second, a mandated offering law can require that if MH/SUD benefits are offered, then their coverage must be equal to that provided for physical illnesses. *Id.*

¹⁶ ARK. CODE § 23-99-502 (emphasis added).

Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders.”¹⁷ The Act further states that “[u]nless specifically otherwise stated, ‘mental illness’ includes substance use disorders.”¹⁸ The DSM-IV lists nicotine dependence as a psychological disorder.¹⁹ The ICD-10 considers tobacco addiction to be a mental/behavioral disorder.²⁰

Given the DSM and ICD’s definitions of nicotine dependence as a psychological disorder and the Arkansas Mental Health Parity Act’s coverage of all mental illnesses, it may initially seem as though an insurer doing business in Arkansas may not exempt tobacco cessation services from the coverage of its group health insurance plans. However, like the MHPAEA, the Arkansas Act merely requires parity in duration or frequency of coverage, dollar amount of coverage, or financial requirements where a plan already opts to provide mental health or substance use disorder benefits.²¹ It does not mandate the provision of such benefits.

Preemption Considerations

As noted above, the vast majority of states have health parity acts that complement the MHPAEA. The MHPAEA is deferential to state law; state health parity acts need not mirror the language of MHPAEA in order to safeguard against federal preemption.

The current HIPAA preemption standard applies to state health parity acts. This standard is extremely protective of state law. Only a state law that "prevents the application" of the Act will be preempted, which means that stronger state parity and other consumer protection laws remain in place and can be enforced concurrently with MHPAEA. Specifically, the summary to the February 2010 interim final rules states, with respect to federal preemption of state laws:

The preemption provisions of [ERISA and HIPAA] apply so that the MHPAEA requirements are not to be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of MHPAEA. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws.

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the MHPAEA requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the federal requirements are unlikely to “prevent the application of” MHPAEA, and be preempted.

¹⁷ ARK. CODE § 23-99-503(6)(A).

¹⁸ ARK. CODE § 23-99-503(6)(B).

¹⁹ AMERICAN PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (2000) (“DSM-IV”), 305.10.

²⁰ WORLD HEALTH ORG., INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS, 10TH REVISION (2007) (“ICD-10”), Ch. V, F17, *available at* <http://apps.who.int/classifications/apps/icd/icd10online/>.

²¹ ARK. CODE § 23-99-506.

Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.²²

We are not familiar with any instances where state health parity acts have been challenged because they did not meet the minimum requirements of the MHPAEA, largely because the law is relatively new and the effective date has not elapsed for all covered plans. The Act requires the Comptroller General to inform Congress on health plans' and health insurers' coverage and exclusion rates, patterns, and trends of mental health and substance use disorder diagnoses.

It may be possible for a state law or regulation to exempt tobacco cessation coverage by expressly listing nicotine dependence as a condition *not* covered by the state's health parity act. Indeed, some states have specifically exempted tobacco cessation in their state health parity acts. Looking at the plain language of the text of the MHPAEA, it is not clear that the federal act would necessarily preempt such a state law. However, it is difficult to see how such an exemption would be compatible with the MHPAEA's statement that "[a]ny 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," the Act's reference to the DSM-IV and ICD-10 as such generally recognized standards, and both of those publications' definitions of nicotine dependence as substance abuse-induced psychological disorders.

An Arkansas Insurer's Apparent Interpretation of the MHPAEA

You have asked us whether an Arkansas insurer who provides a tobacco quitline will be offering a treatment benefit under the MHPAEA, and be required to offer it in parity with other benefits. Based on the information you provided, it appears as though an Arkansas insurer is concerned that if it offers a tobacco quitline, this service will be construed as an outpatient treatment benefit for a substance use disorder (nicotine dependence), and that offering that benefit will require the insurer to offer benefits in the other classifications (e.g., inpatient, prescription drugs, etc.) for nicotine dependence on parity with other medical/surgical benefits under the MHPAEA. Concern about this interpretation, and its cost implications, has led the insurer to question whether it will provide a tobacco quitline to its insureds. While such an interpretation and resulting action would appear to be unjust and unwise from a public health perspective, it does not necessarily appear to violate federal or state law. Such an interpretation might be susceptible to challenge on federal preemption grounds, but the result is unclear, since the MHPAEA is highly deferential to state law and does not expressly define nicotine dependence, or any specific mental health or substance use disorder for that matter, as a covered condition under the Act.

It is also possible that, even if nicotine dependence is construed to be a covered condition under the MHPAEA, there is a way to characterize a tobacco quitline as a service not covered by the Act. However, it appears that the only way this interpretation might succeed is if the quitline was a component of a stand-alone worksite wellness program or an employee assistance program ("EAP") with no nexus to the employer's insurance plan. Generally, EAP benefits are separately

²² *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, 75 Fed. Reg. 5410, 5430 (Feb. 2, 2010) (citations omitted).

packaged employee benefits that are unlikely to be considered part of the insured health care benefits under the MHPAEA. But even this interpretation might be susceptible to challenge, since the Act specifically covers mental health and substance use services.

We hope these comments are helpful. Please let us know if we can be of any further assistance on this or any other tobacco-law related issue that comes to the Public Health Law Network – Southeastern Region’s attention.

Sincerely,

Kate Armstrong
Staff Attorney