



Ending Addiction
Changes Everything

IMPLEMENTING AND ENFORCING MHPAEA REQUIREMENTS



**GUIDE TO IMPLEMENTING AND ENFORCING
MENTAL HEALTH PARITY and ADDICTION EQUITY ACT
(MHPAEA) REQUIREMENTS FOR ADDICTION PREVENTION AND
TREATMENT BENEFITS**

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The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) requires covered health care plans that offer addiction* and mental health benefits to offer these benefits on par with coverage for medical and surgical benefits. The Departments of the Treasury, Labor and Health and Human Services issued an Interim Final Rule in 2010, and in November 2013, the Departments released a Final Rule to implement MHPAEA. The *Patient Protection and Affordable Care Act* (ACA) of 2010 extended the application of parity to individual and small market plans not previously subject to MHPAEA requirements.

While MHPAEA does not mandate coverage of specific benefits for addiction services, the scope of addiction benefits offered must be comparable to the scope of benefits for medical/surgical care. Neither the MHPAEA nor the Final Rule, however, provides a blueprint for optimum or effective services. To fill this gap, CASAColumbia® offers this guide to state regulators of commercial health plans. This guide was developed for state regulators because states have primary enforcement responsibility for MHPAEA as it applies to most commercial group health plans and health insurance issuers in the group and individual markets.

This guide includes:

- The critical addiction prevention and treatment benefits that health plans should offer.
- Examples of how limitations placed on coverage of addiction benefits, such as excessive prior authorization requirements and fail-first policies, can undermine addiction care and why they should not be used.
- A summary of basic requirements of MHPAEA and the Final Rule.

Addiction and risky substance use affect millions of Americans and cause or contribute to dozens of other health conditions, resulting in considerable costs within the health care system and driving many other costly social problems. Preventing risky use and effectively treating addiction improves health outcomes for patients and will likely reduce health care costs for insurers. However, if the level of care provided to patients is insufficient it can be ineffective, leading to relapse, additional care and additional costs. On the other hand, receiving too high a level of care can be unnecessarily costly and not improve outcomes. Health plans should cover a full range of benefits proven to prevent and treat addiction and offer these benefits without limitations that could impede access to care.

* Defined in the law and regulations as “substance use disorder” but referred to here as “addiction.” While MHPAEA applies to both addiction and mental health benefits, this guide focuses on the application of the law to addiction benefits.

Why Is Providing Comprehensive Coverage for Risky Use and Addiction Services Important?

Risky substance use and addiction together constitute America's largest and most expensive preventable health problem. Addiction involving nicotine, alcohol and other drugs affects 16 percent of the population--more than the percentage with heart disease, cancer or diabetes.¹ Another 32 percent of the population is risky users who, while not addicted, use substances in ways that can threaten health and safety.² Risky substance use and untreated addiction contribute to more than 70 other health conditions requiring medical attention including cancer, respiratory disease, cardiovascular disease, HIV/AIDS, pregnancy complications, cirrhosis, ulcers and trauma.³ Persons with untreated addiction are among the highest-cost health care users in America:⁴ they have higher utilization rates, more frequent hospital admissions, longer hospital stays and require more expensive health care services.⁵ Nearly one-third (32.3 percent) of all hospital inpatient costs are attributable to risky substance use and addiction involving nicotine, alcohol and other drugs.⁶

In the health care system, risky substance use can be addressed through screening and brief intervention, and addiction can be treated and managed with evidence-based approaches, including medications and psychosocial therapies. Unfortunately, our health care system does little to effectively prevent risky substance use or treat and manage addiction. Health care providers do not routinely screen for these problems and only 11 percent of people in need of treatment involving alcohol and drugs other than nicotine receive any form of treatment.⁷ The number of people who receive treatment for addiction involving nicotine is unknown. Of those who do receive treatment for addiction, the vast majority do not receive evidence-based care.

Research suggests that providing clinically-indicated prevention and intervention for risky use and treatment and disease management for addiction not only will improve health outcomes, but will likely reduce both short- and long-term health care expenditures.⁸ For example, a longitudinal study of patients treated for addiction in Kaiser Permanente's Medical Care Program found an average reduction of 30 percent in medical costs three years post treatment; significant declines were seen in areas such as the number of inpatient hospital days and emergency department visits, which are high-cost services.⁹

Critical Addiction Prevention and Treatment Benefits that Health Plans Should Offer

In 2012, CASAColumbia released *Addiction Medicine: Closing the Gap between Science and Practice*, a five year national study that examined the science of addiction and how to effectively prevent and treat it.* The primary finding of the study is that a wide range of evidence-based screening, intervention, treatment and disease management health care practices are available to reduce risky use of addictive substances and prevent and treat addiction; however, the gap between what works and what patients actually receive is substantial.

The CASAColumbia report identified a list of critical addiction services that have been proven by research to effectively prevent risky substance use and treat and manage addiction. These evidence-based services are consistent with the recommendations of other leaders in this field who have reviewed the data,¹⁰ including The Coalition for Whole Health's (CWH) *EHB Consensus Principles and Service Recommendations*,¹¹ which have the support of over 100 national- and state-level mental health/addiction organizations.¹²

The critical addiction-related health services that health plans should cover are:

- **Routine Screening and Brief Intervention (SBI) in Health Care Settings, including Primary and Urgent Care.** All patients should be routinely screened for all forms of risky substance use--including tobacco/nicotine, alcohol, illicit drugs and controlled prescription drugs--at the initial visit to a primary care (including family and internal medicine, pediatric and obstetric), mental health or specialty care physician, and then routinely thereafter, and upon admission to a hospital, emergency department or trauma care center. Because the disease of addiction in most cases originates with substance use in adolescence, it is important to screen young patients using age-appropriate screening tools. As part of these services, patients (and their families if appropriate) should be educated about the health consequences of risky substance use, the disease of addiction and risk factors for both. Individuals who screen positive should be referred for a full diagnostic evaluation. For those who engage in risky substance use that does not meet the threshold of clinical addiction, a brief intervention (typically involving motivational interviewing techniques and substance-related education) is an effective, low-cost approach for reducing risky substance use.¹³

* To fully understand the available tools for effective interventions and for treatment, the gap between the need for such interventions and treatments, and the actual standard of care and the driving forces behind this substantial gap, CASAColumbia conducted a thorough review of more than 7,000 scientific articles, reports, books and other reference materials; secondary analysis of five national data sets; interviews with 176 leading experts in a broad range of fields relevant to the report; two statewide surveys of addiction treatment providers in New York; an online survey of 1,142 members of professional associations involved in addiction care and related research; and an in-depth analysis of state and federal governments' and professional associations' licensing and certification requirements for individual treatment providers and addiction treatment facilities and programs, as well as accreditation requirements for facilities and programs.

- **Diagnostic Evaluation, Comprehensive Assessment, Patient Placement and Treatment Planning.** For individuals showing signs of addiction, it is necessary to determine a clinical diagnosis including the severity of the disease. If the disease is present, a comprehensive assessment must be performed to evaluate co-occurring medical (including psychiatric) conditions and personal circumstances that may affect treatment success. The results of the diagnostic evaluation and comprehensive assessment create the foundation for an effective treatment plan that is individualized and tailored to the patient, identifies the pharmaceutical and behavioral therapies needed, and the appropriate level of care for patient placement. Diagnosis and treatment planning should be conducted using standardized and validated instruments.
- **Stabilization/Withdrawal Management.** As a precursor to treatment, the patient's condition should be stabilized to reduce acute symptoms via cessation of substance use, including medically-supervised withdrawal management ("detoxification") or use of medication when necessary. Stabilization alone is not treatment for addiction. After stabilization, connecting patients with services to treat and manage their addiction is a critical step in assuring that stabilization services are clinically and financially effective.

All patients should be evaluated to: a) determine the presence and severity of withdrawal symptoms using standardized instruments when available, b) assess potentially complicating co-occurring medical (including psychiatric) conditions, c) detect (through the use of drug testing) any substances present or recently used in the patient's body, and d) establish the patient's withdrawal history. A trained physician should determine the appropriate setting (e.g., patient's home, physician's office, non-hospital treatment facility, intensive outpatient/partial hospitalization program or inpatient hospital) for stabilization based on the results of the diagnosis and evaluation. Patients should be supported through stabilization (with the use of medication when necessary) to re-establish a state of physiological stability. Patients with addiction involving opioids may be immediately transitioned to long-term medications to prevent withdrawal symptoms and reduce cravings. Once stabilized, all patients should receive addiction treatment immediately.

- **Addiction Treatment.** Qualified health care professionals should deliver evidence-based addiction treatments, accompanied by treatment for co-occurring health (including psychiatric) conditions. Depending on the severity of the patient's disease and the general health status of the patient, the use of medications, psychosocial therapies or both in combination may be necessary. All services necessary to coordinate addiction treatment with other health care services also should be covered.
 - **Pharmaceutical therapies.** Pharmaceutical therapies can be an important component of addiction treatment.¹⁴ Individual factors, including genetic and biological characteristics and environmental and psychological risk factors, may determine how effective a certain type of pharmaceutical intervention will be for an individual with addiction. All FDA-approved medications designed to treat and manage addiction should be covered.

These medications include, but are not limited to:

- 1) bupropion (Zyban, Wellbutrin); varenicline (Chantix); and the five FDA-approved forms of nicotine replacement therapy (NRT), including patch, gum, lozenge, nasal spray and inhaler for addiction involving nicotine;
- 2) acamprosate (Campral); naltrexone formulations (ReVia, Depade, Vivitrol); and disulfiram (Antabuse) for addiction involving alcohol; and
- 3) naltrexone formulations (ReVia, Depade, Vivitrol); methadone (Methadose); and buprenorphine + naloxone (Suboxone, Subutex, Zubsolv) for addiction involving opioids.

The above medications have different mechanisms of action and should not be considered interchangeable members of the same “class.” Some may be effective when used for short periods of time; others are most effective when used for long-term duration. Physicians, using their clinical judgment, have the authority to prescribe medications that are not FDA-approved specifically to treat addiction, just as is the case when physicians treat other illnesses; these medications also should be covered.

Benefits should include all clinical services required for patients to access the pharmacotherapies, such as physician visits for medical management of pharmaceutical therapies, as well as coverage for treatment at licensed opioid treatment programs when required for access to certain medications (e.g., methadone or buprenorphine to treat addiction involving opioids).

- **Psychosocial therapies.** Psychosocial therapies are critical components of almost every treatment regimen; when combined with pharmaceutical treatments they enhance treatment efficacy.¹⁵ Psychosocial therapies must be tailored to individual patient characteristics, such as age, gender and sexual orientation. Evidence-based psychosocial therapies include, but are not limited to:
 - 1) Cognitive-Behavioral Therapy (CBT);
 - 2) Motivational Interviewing (MI) and Motivational-Enhancement Therapy (MET);
 - 3) Community Reinforcement Approach (CRA);
 - 4) Contingency management/motivational incentives;
 - 5) Behavioral couples/family therapy;
 - 6) Multidimensional family therapy; and
 - 7) Functional family therapy.

Benefits should include physician visits to coordinate and supervise care if the above psychosocial therapies are delivered by non-physician providers.

- **Level and length of treatment.** The appropriate level of care should be determined by the results of a diagnostic evaluation and a comprehensive assessment.

At a minimum, health plans should cover the following levels of care where evidence-based services are provided:

- 1) Outpatient treatment;
- 2) Intensive outpatient treatment;
- 3) Partial hospitalization;

- 4) Inpatient hospitalization; and
- 5) A range of non-hospital residential treatment environments (including low-intensity, high-intensity, and population specific).

The medically-indicated length of treatment varies depending on the severity and complexity of the patient's disease and other factors. Length of treatment should be flexible, contingent on periodic evaluation of the patient's progress. Blanket limitations on allowed visits or lengths of stay do not accord with best practices for treating addiction, nor do program-driven lengths of stay.

Many people with addiction have co-occurring health (including psychiatric) conditions; often these co-occurring conditions must be treated concurrently for any treatment to be successful. Plans should cover addiction treatment services and levels of care that allow for concurrent treatment of all health conditions.¹⁶

CASAColumbia strongly recommends that plans cover all levels of care, including partial hospitalization and residential treatment which frequently have either been excluded or paid for less often than other levels of care. In order to be effective, both the level of care and duration of addiction treatment should be matched to the individual patient's treatment needs (as determined by a comprehensive assessment). For example, residential treatment is essential for some individuals, including those who need a safe and stable living environment where treatment services are provided. For patients who have a supportive living environment, outpatient treatment is often indicated, but those with more complex cases of addiction and/or those with other serious medical, including psychiatric, conditions may need treatment in a more intensive level of care.

Covering these services is in the best interests of insurers. Placing patients into the wrong level of care is counterproductive. If the level of care is insufficient, it can be ineffective, leading to relapse, additional care and additional costs; receiving too high a level of care can be counterproductive and not improve outcomes. Providing the full spectrum of benefits can reduce the number of patients who utilize the most expensive level of care, which is inpatient care. Assuring the full range of services can be expected to improve health and reduce costs to insurers.

- **Monitoring, Support and Continuing Care.** Because addiction can be a chronic, relapsing disease, monitoring, support and continuing care services are essential to help the patient maintain the progress achieved during the initial phase of addiction treatment and to prevent relapse. Ongoing pharmaceutical and psychosocial therapies are often indicated to manage the disease, as for persons with other chronic conditions like diabetes or hypertension.

Benefits should include the full range of services required to manage a chronic condition. These services include:

- Continued pharmaceutical and psychosocial therapies, supervised by a physician;
- Follow-up appointments to monitor progress;

- Disease management services to promote patients' adherence to a treatment regimen; and
- Case management services to connect patients with resources, including peer support (e.g., Alcoholics Anonymous, LifeRing Secular Recovery, Narcotics Anonymous, Secular Organizations for Sobriety, SMART Recovery, Women for Sobriety, etc.) and auxiliary services--such as legal, educational, vocational, housing, child care and family supports as well as nutrition and exercise counseling. Peer support programs are an important adjunct to treatment; however, these programs do not constitute treatment themselves.

Examples of How Treatment Limitations Placed on Addiction Benefits Can Undermine Addiction Care and Why They Should Not Be Used

While MHPAEA and the Final Rule give examples of tests to determine when financial requirements and treatment limitations (both quantitative and non-quantitative) can violate parity, they do not explain how these limitations can potentially compromise the effectiveness of addiction services. CASAColumbia offers the following examples that explain how the design and application of treatment limitations could limit patients' access to necessary, clinically indicated care and undermine treatment:

- **Prior Authorization.** Because addiction affects the parts of the brain associated with motivation, decision making, risk/reward assessment and impulse control, engaging and retaining patients in treatment can be difficult. Failing to retain patients can result in serious consequences for the patient, including returning to substance use, medical complications, overdose and death. Prior authorization can add a further barrier to the already complex process of motivating patients to begin and stay in treatment. Excessive authorization requirements are not clinically appropriate, as they can delay necessary clinical care and inhibit access to appropriate clinical services.¹⁷ For example, best practices for addiction treatment require moving patients immediately from stabilization services to treatment.¹⁸ Barriers such as prior authorization that impede the immediate delivery of treatment services after stabilization increase the risk that the patient will relapse and possibly overdose due to lowered tolerance--resulting in negative outcomes for the patient and increased health care spending for the health plan.
- **Fail-first Policies.** There is no clinical evidence to support the use of fail-first policies in addiction treatment. Clinical practice guidelines call for a comprehensive assessment of each patient to determine the appropriate therapies and level of care given the severity of the patient's addiction and the presence of co-occurring health conditions and other social/environmental factors.¹⁹ Requiring a patient to fail treatment at one level of care or to fail one specific therapy before starting clinically indicated care does not accord with these guidelines. In fact, the application of fail-first policies in addiction treatment can negatively impact the timing and efficacy of treatment or deter patients from seeking needed treatment. For example, requiring a patient to fail psychosocial therapy before authorizing pharmaceutical therapy could undermine patient care. Pharmaceutical and psychosocial addiction therapies tend to work best when delivered together,²⁰ which is why the concurrent delivery of these treatments is generally recommended.²¹ Patients who would benefit from medications but do not receive them may relapse and quit their therapy, and so it is

important that these treatments be delivered together. Another example is to require a patient to fail one medication before authorizing another medication. This could undermine care because addiction medications often have distinct mechanisms of action and help the patient achieve different outcomes (e.g., for addiction involving alcohol, acamprosate is better for maintaining abstinence while naltrexone is better for reducing heavy drinking and craving).²² The use of fail-first policies in these examples has the potential to compromise health and increase costs to the health plan.

- **Level of Care Exclusions.** Clinical practice guidelines for addiction treatment call for a comprehensive assessment to determine the patient's clinical and social circumstances, and then placement in the appropriate level of care that is equipped to provide the services necessary to address these circumstances. A range of levels of care is necessary because different levels offer different types and intensities of services.²³ Within the different levels of care, treatment can be tailored to meet the specific needs of the individual presenting for treatment, an essential component of effective care. Unconditionally excluding a level of care limits a patient's treatment options and could lead to worse outcomes for the patient. For example, if a patient seeks treatment for addiction involving alcohol, has co-occurring depression and has an unstable living environment, the patient may require treatment in a residential setting. If residential care is not available to the patient, the patient may seek care at an outpatient setting where the patient's needs will not be addressed adequately or at a hospital inpatient setting where more care than needed may be provided at an unnecessarily high cost. Allowing for access to a range of levels of care improves patient outcomes by matching patients to the appropriate level of care for their needs and can be expected to decrease costs to the health plan in the long-term.
- **Treatment Planning Requirements.** While treatment plans are essential for determining, guiding and documenting treatment, requiring that a treatment plan be fully in place before starting addiction treatment can limit patients' access to services and delay care. In cases where a patient needs services immediately, this requirement could endanger the patient's health by delaying care, possibly causing the patient to relapse, which can, in turn, lead to higher health care costs in the future. In addiction care, the treatment plan should at least identify the severity of addiction, level of care for placement and the types of services to be delivered before the patient begins treatment. Soon after the patient begins treatment, the plan should describe other factors relevant for care, such as a patient's priorities and goals for treatment, specific treatment protocols for both the addiction and co-occurring conditions and support services to be provided. When treatment planning requirements restrict access to care, costs to the health plan can be expected to rise.
- **Reimbursing Only for Short-term or Acute Care Services.** Addiction can be a chronic disease, with rates of relapse and medication adherence that are similar to other chronic diseases, such as diabetes and hypertension.²⁴ As a chronic disease, addiction requires ongoing treatment and monitoring; limitations such as blanket restrictions on allowed visits or lengths of stay do not accord with best practices for addiction treatment.

Another example is stabilization, an important service for those experiencing withdrawal or severe intoxication. It is often required before a course of treatment can begin, but it is not treatment.²⁵ If a health plan only pays for stabilization, it is

only paying to help the patient stop using addictive substances rather than paying for treatment of the underlying disease. Unless treatment is provided, the cessation of use is likely to be temporary, requiring repeat episodes of stabilization and possibly requiring higher levels of care, leading to increased costs for the health plan.

- **Provider Inclusion Criteria and Restrictions Based on Geographic Location.**

For most diseases other than addiction, treatment is provided within a highly-regulated health care system. In contrast, patients with addiction currently are referred to a broad range of providers largely exempt from medical training and standards who work within a fragmented system of care with inconsistent regulatory oversight. CASAColumbia's state-by-state analyses of regulations and statutes found that the education and training requirements for addiction treatment providers vary greatly from state to state and that the requirements are often minimal.²⁶ For example, CASAColumbia's research found that 14 states do not require addiction counselors in all settings to be licensed or certified and that only one state requires a master's degree as the minimum education requirement for addiction counselors.²⁷

Without adequate training, providers are not capable of performing health assessments, prescribing pharmaceutical medications, treating co-occurring health conditions or managing a chronic disease, each of which is an essential evidence-based addiction treatment practice. Those without an advanced education are less likely to be trained in the scientific method or clinical research, further impeding their ability to integrate clinical research findings about effective treatment into practice.

Because of these inconsistent state licensing requirements, health plans may choose to require that all addiction treatment providers have at least a master's degree and supervised clinical experience. While this limitation complies with MHPAEA and should improve the quality of care, it can also reduce the number of providers in the network. To ensure adequate access to qualified providers, health plans can expand their provider networks in two ways:

- Include a range of treatment providers who meet the criteria to be in the network (e.g., addiction medicine physicians, addiction psychiatrists, clinical psychologists, and clinical social workers, clinical mental health counselors and licensed or certified addiction counselors with at least a master's degree and supervised clinical experience).
- Allow patients to see providers who are out-of-network or out-of-state without additional charge when there are not enough providers in their area.

Summary of Basic Requirements of MHPAEA and the Final Rule

Historically, health plans have offered less coverage for mental health and addiction benefits--covering fewer benefits at lower levels with more restrictions--than for medical/surgical benefits.²⁸

The *Mental Health Parity Act of 1996* (MHPA) previously required parity in annual and lifetime dollar limits for mental health and other medical benefits but excluded addiction.²⁹ In 2008, MHPAEA expanded on the earlier law by applying it to addiction benefits and requiring parity in both quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs) as well as financial requirements for covered benefits.³⁰ For health plans subject to MHPAEA, parity applies to the following six benefit classifications, if offered: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.³¹ Neither MHPA nor MHPAEA *require* insurance plans to offer addiction benefits, although the ACA requires certain plans to offer addiction benefits, as described below.

MHPAEA was enacted to ensure that people with mental health disorders or addiction receive health care for these conditions that is on par with care offered for other medical conditions. Equity among benefits for addiction prevention and treatment is ensured in several ways, including:

- ✓ If a plan offers addiction benefits in at least one classification of benefits, then it must offer addiction benefits in every classification where medical/surgical benefits are offered.³²
- ✓ A financial requirement (e.g., co-pays, deductibles or out-of-pocket maximums) or quantitative treatment limitation (e.g., annual or lifetime day or visit limits) placed on addiction benefits cannot be more restrictive than the “predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification.”³³
- ✓ Non-quantitative treatment limitations (e.g., medical necessity review, prior authorization) must be “comparable to” and “applied no more stringently than” non-quantitative treatment limitations placed on medical/surgical benefits.³⁴
- ✓ Cumulative financial requirements or treatment limitations cannot accrue separately for addiction and medical/surgical benefits (in any one classification).³⁵ Separate financial requirements or treatment limitations applicable only to addiction benefits are prohibited.³⁶
- ✓ Plans must disclose to members the criteria used for medical necessity determinations and the reason for any denial of reimbursement or payment.³⁷
- ✓ Plans must disclose the comparative analysis of how medical management standards are applied to addiction versus medical/surgical benefits.³⁸

The Final Rule applies to group health plans/health insurance coverage and individual health insurance coverage effective July 1, 2014. States have primary enforcement responsibility for MHPAEA as it applies to most commercial group health plans and

health insurance issuers in the group and individual markets.³⁹ However, if the Department of Health and Human Services (HHS) determines that a state is not "substantially enforcing" the law, it can conduct secondary enforcement to bring plans into compliance.⁴⁰ HHS has primary enforcement authority over non-Federal government health plans, such as health plans sponsored by state and local government employers.⁴¹ The Departments of Labor and the Internal Revenue Service (IRS) have enforcement authority over private employer-sponsored group health plans.⁴²

The Final Rule clarifies that MHPAEA does not preempt state parity laws that have greater requirements, such as mandates that issuers provide coverage for mental health or addiction. If a state mandates this coverage, then the coverage must comply with MHPAEA, and the issuer may have to provide a greater level of benefits beyond what is required by state law.⁴³

MHPAEA includes an increased cost exemption for plans or issuers. Under this exemption, a plan or issuer must demonstrate that compliance with the law resulted in at least a two percent cost increase in the first year parity applies to the plan/coverage or at least a one percent increase for any year after.⁴⁴ The final regulations include a formula for how plans and issuers can determine increased cost as a result of compliance and the term of the exemption is one year.⁴⁵

Other key provisions of the Final Rule are:

- **Application of MHPAEA to Insurance Markets and Programs.** MHPAEA applies to most employer-based health plans, individual and small group market plans, Medicaid Managed Care Organizations (MCOs), Medicaid alternative benefit plans and the Children's Health Insurance Program (CHIP).⁴⁶ The Final Rule, however, does not apply to Medicaid MCOs, Medicaid alternative benefit plans and CHIP.⁴⁷ The Centers for Medicare and Medicaid Services released a letter to state health officials on January 16, 2013 explaining how principles of MHPAEA apply to these three plans, but the agency has not yet issued final guidance for them.⁴⁸

The ACA expands the reach of MHPAEA by requiring non-grandfathered health insurance coverage in the individual and small group markets to offer addiction benefits as part of their essential health benefits (EHB) package and to ensure these benefits comply with MHPAEA.⁴⁹ In 2013, CASAColumbia released recommendations to the states for addiction prevention and treatment benefits that should be included in health plans, [available online](#). The ACA also prohibits all lifetime and annual limits on the dollar amount of EHB, including addiction benefits.⁵⁰ The ACA extends parity to Qualified Health Plans (offered through state health insurance marketplaces)⁵¹ and to grandfathered coverage offering addiction benefits in the individual market.⁵²

- **Prohibited Financial Requirements and Treatment Limitations under MHPAEA.** MHPAEA prohibits health plans that offer addiction benefits from imposing financial requirements or (QTLs) on those benefits that are *more restrictive than the predominant requirement or limitation that applies to substantially all medical/surgical*

* With the exception of grandfathered small employer plans, retiree-only plans, church-sponsored plans and self-insured plans sponsored by state and local governments. Other plans exempt from MHPAEA include: TriCare, Medicare, and traditional fee-for-service Medicaid.

benefits offered in the same classification.⁵³ The Final Rule clarifies that any financial requirement or treatment limitation must be compared only to the financial requirements or treatment limitations of the same type (e.g., co-pays) within the same classification.⁵⁴

- ***The test for financial requirements and quantitative treatment limitations.*** Financial requirements include deductibles, co-pays, coinsurance, or out-of-pocket maximums, but not aggregate lifetime or annual dollar limits.⁵⁵ Quantitative treatment limitations (QTLs) are limits on the scope or duration of treatment that can be expressed numerically, such as annual visit limits.⁵⁶

The Final Rule offers a mathematic formula for applying the “predominant and substantially all” test to financial requirements and QTLs: “predominant” means more than one-half and “substantially all” means at least two-thirds.⁵⁷

- ***The test for non-quantitative treatment limitations.*** Non-quantitative treatment limitations (NQTLs) are limitations on the scope or duration of benefits for treatment⁵⁸ that cannot be expressed numerically, such as medical necessity review, formulary design for prescription drugs, standards for provider admission in networks (including reimbursement rates), determination of usual/customary/reasonable charges, fail-first or step therapy protocols, restrictions based on geographic location, facility type, provider specialty, etc., and exclusions based on failure to complete course of treatment.⁵⁹

The Final Rule provides a separate test for NQTLs:⁶⁰ “Any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to” addiction benefits in each classification 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 in the same classification.”⁶¹ The Final Rule further clarifies that comparable means that the processes, strategies, evidentiary standards and other factors cannot be “specifically designed to restrict access to” addiction benefits.⁶² However, an NQTL does not violate parity if it is applied comparably, and no more stringently, to both addiction benefits and medical/surgical benefits but results in application to proportionately more addiction benefits.⁶³ In other words, MHPAEA requires equity in processes, not outcomes.

- **Scope of Benefits Requirements under MHPAEA.** MHPAEA and the Final Rule identify six classifications of benefits where parity applies. The Final Rule allows plans to divide the six classifications of benefits into “sub-classifications” in particular cases. Outpatient benefits can be subdivided into “office visits” and all other outpatient items and services (e.g., outpatient surgery); the parity rule must then be applied to all benefits within each sub-classification.⁶⁴ Plans that provide benefits through multiple tiers of providers (e.g., preferred vs. non-preferred providers) and offer more generous cost-sharing for preferred tiers (e.g., lower co-pays) can divide

* The Final Rule clarifies that the mathematical “predominant and substantially all” test does not apply to NQTLs, and that only the “comparable to” and “no more stringently than” test applies. Also, the Final Rule eliminated the “recognized clinically appropriate standards of care” exception that was set forth in the Interim Final Rule.

in-network benefits into sub-classifications that reflect those tiers, but only if the tiers are based on reasonable factors and without regard to whether providers are addiction or mental health providers.⁶⁵ Similarly, tiered pricing is allowed for pharmaceutical drugs if the tiers are based on reasonable factors not related to the distinction between medical/surgical versus addiction or mental health drugs.⁶⁶

MHPAEA and the Final Rule mandate a minimum scope of benefits across the six benefit classifications by requiring that if a plan or health insurance coverage offers addiction benefits in any one of the six classifications, it must offer such benefits in every classification in which medical/surgical benefits are offered.⁶⁷

While MHPAEA and the Final Rule do not require plans to cover any *specific* services for addiction *within* each benefit classification, in practice, they require a scope of benefits within each classification that is comparable to the scope of benefits for medical/surgical care. The Final Rule requires a comparable scope of services within classifications by applying the NQTL test, described above, to plan exclusions that limit the scope of services provided.⁶⁸ Examples of limitations on scope of services that might violate the NQTL test are:

- ✓ Placing categorical exclusions on a type of addiction service (such as excluding coverage for inpatient, out-of-network addiction treatment) while not doing the same for a medical/surgical service.⁶⁹
- ✓ Excluding an addiction benefit on the basis that it has no medical/surgical equivalent unless the plan also excludes medical/surgical benefits on the basis that they have no addiction equivalent.⁷⁰
- **Intermediate benefits.** Intermediate benefits are those that do not fit neatly into either the inpatient or the outpatient classification. These benefits include intensive outpatient treatment, day/partial hospitalization treatment, and residential (non-hospital) treatment. The Final Rule clearly states that the Departments did not intend to imply that plans could exclude intermediate benefits.⁷¹ However, the rule does not impose a mandate that would require more generous addiction benefits than medical/surgical benefits⁷²--so intermediate benefits for addiction would only be mandatory if similar benefits were provided for medical/surgical care.

According to the Final Rule, plans must assign intermediate addiction benefits to one of the six benefit classifications "in the same way that they assign comparable intermediate medical/surgical benefits to these classifications."⁷³ For example, if the plan covers skilled nursing care or treatment for medical/surgical conditions in a rehabilitation hospital, and it assigns these benefits to the inpatient classification, then it must classify covered residential addiction treatment as inpatient benefits as well.⁷⁴ If a plan covers home health care as an outpatient benefit, then it must cover intensive outpatient and day/partial hospitalization treatment for addiction as an outpatient benefit.⁷⁵

- **Exception for preventive services required by the ACA.** There is one caveat to the scope of benefits requirement. According to the Final Rule, if a plan only covers mental health/addiction services to comply with the ACA's requirement to cover preventive services recommended by the U.S. Preventive Services Task

Force, including screening and counseling for alcohol and tobacco use, then the plan is not required to offer addiction benefits in each of the six classifications under MHPAEA.⁷⁶ Only non-grandfathered plans and coverage in the individual and small group markets and Medicaid alternative benefit plans must offer the full range of EHB, including preventive services and addiction treatment services.

It is in the interest of such plans to offer a full range of benefits for addiction prevention and treatment. Screening and brief intervention are just one part of a framework for prevention and treatment, and if offered alone without evidence-based interventions or treatments for addiction they do little to improve patient outcomes or reduce the burden of risky substance use and addiction on the health care system. Failure to provide treatment services for addiction can also lead to increased costs for insurers. Untreated addiction can complicate the care of other conditions and contributes to the development of other serious illnesses, such as cancer and heart and lung disease. Providing treatment, including specialty care as needed, is critical to managing the disease and any co-occurring conditions and preventing further health and social consequences.⁷⁷

For more information about risky substance use and addiction, best practices for prevention, treatment and disease management, and the consequences of failing to address this disease adequately please see our reports:

[*Addiction Medicine: Closing the Gap between Science and Practice*](#)
[*Adolescent Substance Use: America's #1 Public Health Problem.*](#)

Recommended Online Resources for Guidance on Parity Compliance

- The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*:
<http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/MHPAEA.pdf>
- Final Rules Under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*:
<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>
- Department of Labor, Employee Benefits Security Administration, “Frequently Asked Questions about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation”:
<http://www.dol.gov/ebsa/faqs/faq-aca17.html>
- The Center for Consumer Information & Insurance Oversight, “Mental Health Parity and Addiction Equity Act (MHPAEA)”:
http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
- Centers for Medicare and Medicaid Services, The Center for Consumer Information & Insurance Oversight, “Affordable Care Act Implementation FAQs – Set 17”:
http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs17.html
- Centers for Medicare and Medicaid Services, The Center for Consumer Information & Insurance Oversight, “Affordable Care Act Implementation FAQs – Set 18”:
http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html
- Centers for Medicare and Medicaid Services, “Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans”:
<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>
- The Substance Abuse and Mental Health Services Administration, “Mental Health Parity and Addiction Equity”:
<http://beta.samhsa.gov/health-reform/parity>
- Parity Implementation Coalition, “Understanding the Law”:
<http://parityispersonal.org/Understanding-the-Law>

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