IMPROVING INSURANCE COVERAGE FOR ADDICTION

Center on Addiction's insurance work aims to promote access to quality care by improving insurance coverage for the full range of medically-necessary treatments for substance use disorders (SUDs). We conduct research to identify where gaps in insurance coverage exist and to develop recommendations to promote better coverage.

About Our Research

In 2016, our research focused on whether the SUD benefits offered in commercial plans are adequate to treat addiction and comply with the ACA and parity requirements. We issued a report, *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*, which evaluated the SUD benefits in each state's "EHB Benchmark Plan" – the state's selected template for insurance benefits. This research set the groundwork for ongoing monitoring of SUD benefits in commercial insurance plans and evaluation of the Affordable Care Act's impact on increasing access to evidence-based SUD care.

In 2017, we examined a national sample of commercial plans modeled on the EHB Benchmark Plans to determine whether the benefits offered to consumers comport with the benchmark and whether they offer adequate coverage for effective SUD treatment.

Details of Our Review

We reviewed commercial plans to determine whether the plan: (1) satisfies the ACA's requirements regarding coverage of SUD benefits; (2) complies with federal parity law requirements; (3) provides adequate care for SUDs by covering the full range of critical SUD benefits without imposing harmful treatment limitations; and (4) provides enough information in the plan documents to sufficiently evaluate compliance and adequacy of benefits.

About this Tool

Our Center developed the below tool to assist states and issuers in improving SUD benefit coverage among commercial plans subject to the Affordable Care Act's requirements. Our tool summarizes ACA and parity requirements; offers examples of parity violations or possible violations identified in our review; defines critical SUD benefits; provides best practices recommendations for benefit administration; and identifies examples of what we consider satisfactory SUD benefit language from states' 2017 EHB benchmark plans as well as plans sold in 2017. Adoption and enforcement of these best practices should promote improved coverage of evidence-based SUD interventions.

Center on Addiction

TOOL FOR IMPROVING SUD BENEFIT COVERAGE IN ACA PLANS

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COMPLIANCE WITH THE ACA'S REQUIREMENTS TO COVER SUD BENEFITS

The Affordable Care Act (ACA) requires most individual and small group health plans (ACA Plans) to cover mental health and SUD benefits under the requirement to cover 10 categories of benefits, known as Essential Health Benefits (EHB). ACA Plans are also required to cover certain SUD benefits under the preventive services and prescription drugs EHB categories.

AFFORDABLE CARE ACT REQUIREMENTS	RECOMMENDATIONS REGARDING BEST PRACTICES FOR BENEFIT ADMINISTRATION	SUD BENEFIT LANGUAGE FROM STATES' 2017 EHB BENCHMARK PLANS AND 2017 ACA PLANS
Substance Use Disorder Services[1] Plans must cover mental health and substance use disorder services including behavioral health treatment.	See Adequate Benefit Coverage for SUDs, below	See Adequate Benefit Coverage for SUDs, below
Preventive Health Services[2] Plans must cover: (1) Evidence-based items or services that have in effect an "A" or "B" grade in the current recommendations of the United States Preventive Services Task Force (USPSTF). Tobacco cessation for adults, including behavioral and pharmacotherapy interventions, and tobacco cessation for pregnant women, including behavioral interventions, have an "A" grade in the USPSTF recommendations. Screening for alcohol use and brief behavioral counseling interventions to reduce alcohol misuse in	• Plans should encourage providers to conduct Screening Brief Intervention and Referral to Treatment (SBIRT), a bundle of services shown to reduce risky substance use and prevent substance use disorders. • Plans should reimburse providers for screening patients of all ages for all forms of substance use—including tobacco, alcohol, illicit drugs and controlled prescription drugs. • Screenings should include education for patients and their families about the health consequences of risky substance use, the disease of addiction and risk factors for both.	*Benefits for preventive care include the following:* *Benefits will be provided for evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF), including:* *1. Tobacco cessation for adults, including behavioral and pharmacotherapy interventions.* *2. Tobacco cessation for pregnant women, including behavioral interventions.* *3. Screening for alcohol misuse and brief behavioral counseling interventions to reduce alcohol misuse in adults.*

[1] 42 U.S.C. § 300gg-6(a) (2010); 45 CFR § 156.110(a)(5) (2015); 45 CFR § 156.115(a)(3) (2015).
[2] 42 U.S.C. § 300gg-13 (2010); 45 C.F.R. § 147.130(a)(i), (ii) (2011).

AFFORDABLE CARE ACT REQUIREMENTS	RECOMMENDATIONS REGARDING BEST PRACTICES FOR BENEFIT ADMINISTRATION	SUD BENEFIT LANGUAGE FROM STATES' 2017 EHB BENCHMARK PLANS AND 2017 ACA PLANS
adults has a "B" grade in the USPSTF recommendations.[3] (2) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care (Bright Futures) guidelines supported by the Health Resources and Services Administration. The guidelines include alcohol and drug use assessments for adolescents aged 11–21 years.[4]	• Plans should reimburse providers for providing brief interventions for patients who screen positive for risky substance use or who have a very mild SUD (sometimes called substance abuse).	*Benefits will be provided for evidence-informed preventive care and screenings for infants, children and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), including:* *1. Alcohol and drug use assessments for adolescents aged 11–21 years.*[5]
Tobacco Screening and Cessation[6] Plans must cover screening and at least <u>two</u> tobacco cessation attempts per year. A tobacco cessation attempt includes: (1) Four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization, and (2) One 90-day treatment regimen, prescribed by a physician, of any FDA-approved	• Ensure that no prior authorization is required. • Do not place limits on medication quantities or quit attempts.	*"We provide Benefits for Nicotine Replacement Therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. To be eligible for Benefits, these products and medications must be prescribed by your Physician.* *• NRT products can include but are not limited to, nicotine patches, gum, or nasal spray.* *• We provide Benefits for follow-up smoking cessation education and counseling.*

[3] United States Preventive Services Task Force. (2018). *USPSTF A and B Recommendations*. Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
[4] American Academy of Pediatrics & Bright Futures. (2017). *Recommendations for Preventive Pediatric Health Care.* Retrieved from the American Academy of Pediatrics's website: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.
[5] Based on language from the plan documents for the 2017 EHB benchmark plans for the District of Columbia, Maryland, Nevada, New Jersey, Oklahoma, Texas and Wisconsin
[6] U.S. Department of Labor. (2014, May 2). FAQs about Affordable Care Act implementation (Part XIX). Retrieved from https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xix.pdf.

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tobacco cessation medication (including prescription and over-the-counter) without prior authorization.		• *We provide Benefits for completing an approved smoking cessation program."*[7] *"Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis."*[8]
Prescription Drugs[9] Plans must cover at least one drug in each of the four classes for the United States Pharmacopeia (USP) Anti-Addiction/Substance Use Treatment Category,[10] or the same number of drugs in each USP category and class as the state's EHB benchmark plan (whichever is greater): (1) Alcohol Deterrents/Anti-craving Medications: acamprosate (e.g., Campral®), naltrexone (e.g., Vivitrol®, Revia®, Depade®), disulfiram (e.g., Antabuse®) (2) Opioid Dependence Treatments: buprenorphine (e.g., Buprenex®, Butrans®, Subutex®), buprenorphine + naloxone (e.g., Bunavail™, Suboxone®, Zubsolv®,) and	See Adequate Benefit Coverage for SUDs, below	See Adequate Benefit Coverage for SUDs, below

[7] Based on language from the plan documents for Maine's 2017 EHB benchmark plan
[8] Based on language from the plan documents for the 2017 EHB benchmark plans and 2017 ACA Plans for the District of Columbia and Maryland
[9] 45 C.F.R. § 156.122(a)(1) (2014).
[10] United States Pharmacopeia. *USP Medicare Model Guidelines v7.0*. Retrieved from https://www.usp.org/sites/default/files/usp/document/our-work/healthcare-quality-safety/uspmmg_v7_0_w_exampledrugs_rev170206.pdf.

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naltrexone (e.g., Vivitrol®, Revia®, Depade®)[11] (3) Opioid Reversal Agents: naloxone (e.g., Narcan®, Evzio®) (4) Smoking Cessation Agents:* bupropion (e.g., Wellbutrin®, Buproban®, Aplenzin®, Budeprion®, Zyban®), varenicline (e.g., Chantix®) and nicotine *With respect to Smoking Cessation Agents, plans must cover all FDA-approved tobacco cessation medications, pursuant to the ACA's requirement for coverage of tobacco screening and cessation (see above).		

[11] Methadone – a very effective treatment for opioid dependence – is not included in the Opioid Dependence Treatment class because the class is defined by the USP Medicare Model Guidelines and methadone is excluded from Medicare prescription drug (Part D) coverage.

COMPLIANCE WITH PARITY REQUIREMENTS

To satisfy the EHB requirement, SUD benefits must comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Determining compliance with many parity requirements requires a detailed analysis of information typically not provided in plan documents. Nonetheless, plan documents may contain warning signs[12] or "red flags,"[13] which may trigger the need for a detailed parity assessment. Below we provide details on the parity requirements and identify examples of violations and possible violations found in our review.

PARITY REQUIREMENT/ISSUE	ADDITIONAL DETAIL	EXAMPLES OF VIOLATIONS/POSSIBLE VIOLATIONS IDENTIFIED IN REVIEW
Scope of Benefits Plans must offer SUD benefits in every classification of benefits (e.g., inpatient, outpatient, emergency care, prescription drugs) where medical/surgical benefits are offered.[14]	• Intermediate benefits may not fit neatly into either the inpatient or the outpatient classification. For SUDs, such benefits include intensive outpatient treatment, day/partial hospitalization treatment and residential (non-hospital) treatment. MHPAEA does not require plans to cover intermediate services; rather, plans that cover intermediate SUD services must place such services in the same category as comparable intermediate medical services (e.g., home health care, skilled nursing facilities).[15] The parity rules are ambiguous with respect to the exclusion of intermediate SUD services (e.g., residential treatment) when plans cover comparable intermediate medical services (e.g., skilled nursing facility). While some plans interpret MHPAEA regulations strictly and believe that the regulations	• In our review, plans that provide coverage for intermediate medical services but exclude comparable intermediate SUD services are labeled as having a possible parity violation. • We also identified plans that did not include an explicit reference to behavioral health or SUD in the plan's definition of an emergency condition (in our review of SUD Benefit Adequacy).

[12] United States Department of Labor. *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance.* Retrieved from https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.
[13] Legal Action Center. (2018). *Parity Red Flags & Companion Tool*. Retrieved from https://lac.org/parity-red-flags-companion-tool/.
[14] 45 C.F.R. § 146.136(c)(2)(ii) (2011).
[15] 45 C.F.R. § 146.136(c)(2)(ii) (2011).
78 Fed. Reg. 68,240, 68,246–47 (Nov. 13, 2013).

PARITY REQUIREMENT/ISSUE	ADDITIONAL DETAIL	EXAMPLES OF VIOLATIONS/POSSIBLE VIOLATIONS IDENTIFIED IN REVIEW
	would allow for such exclusions, many advocates believe a broader reading of MHPAEA would not permit the scope of services to be covered in an unequal manner and that it may violate the ACA's non-discrimination requirement for EHB.	
Financial Requirements/Quantitative Treatment Limitations Plans must use financial requirements and quantitative treatment limitations (QTLs) for SUD benefits that are no more restrictive than the predominant financial requirements or QTLs that are applied to substantially all medical/surgical benefits in the same classification.[16]	• Applying the "predominant and substantially all" test requires information typically not found in plan documents, including the classification of the SUD benefit, the type of financial requirements/QTLs applied to all medical/surgical benefits in that same classification, and the expected annual dollar amount of all payments made by the plan for the medical/surgical benefits in that classification.[17] Nonetheless, MHPAEA prohibits the use of QTLs (e.g., limits on number of visits) that apply only to SUD benefits or are more restrictive than the QTLs that apply to medical/surgical benefits in the same classification.[18]	• In our review, plans that impose limits on the number of inpatient and/or outpatient visits for SUD services only are identified as having a parity violation.
Cumulative Financial Requirements/Quantitative Treatment Limitations Plans must accumulate cumulative financial requirements (e.g., deductibles) and QTLs	• Cumulative financial requirements (e.g., out-of-pocket maximums) and cumulative QTLs (e.g., lifetime limits) cannot accumulate separately from medical/surgical benefits when such benefits are in the same classification.[20]	• In our review, plans that impose separate requirements on applicability of cost-sharing for SUD services or out-of-pocket maximums are identified as having a parity violation.

[16] 45 C.F.R. § 146.136(c)(2)(i) (2011).
[17] 45 C.F.R. § 146.136(c)(3) (2011).
78 Fed. Reg. 68,240, 68,269 (Nov. 13, 2013).
[18] 78 Fed. Reg. 68,240, 68,241 (Nov. 13, 2013).
[20] 45 C.F.R. § 146.136(c)(3)(v) (2011).

PARITY REQUIREMENT/ISSUE	ADDITIONAL DETAIL	EXAMPLES OF VIOLATIONS/POSSIBLE VIOLATIONS IDENTIFIED IN REVIEW
(e.g., annual limits) for SUD benefits together with cumulative financial requirements and QTLs for medical/surgical benefits when such benefits are in the same classification.[19]		• In our review, plans that impose a lifetime limit on SUD services only are identified as having a parity violation.
Non-Quantitative Treatment Limitations (NQTLs) Plans must use non-quantitative treatment limitations (NQTLs) (e.g., medical necessity review, prior authorization requirement) for SUD benefits that are comparable to and applied no more stringently than NQTLs placed on medical/surgical benefits in the same classification (i.e., plans must use the same rules for creating and applying NQTLs for benefits in the same classification).[21]	• Applying the NQTL test requires information not typically provided in plan documents, including information about how NQTLs are created and applied.	• In our review, if there was a treatment standard that applied only to SUD benefits (e.g., evidence of improvement standard, concurrent review requirement) and the plan documents did not state that the same standard applied to medical/surgical benefits, we identified the standard as an NQTL violation.
Court-Ordered Services Exclusion Exclusions for court-ordered services is an example of an NQTL.[22]	• Exclusions for mental health and SUD court-ordered treatment only are not permissible under MHPAEA.[23]	• In our review of the 2017 ACA Plans, we identified plans that contained a court-ordered services exclusion specific to mental health and/or SUD treatment as having an NQTL violation.
Formulary Design The design of the plan's formulary is an example of an NQTL. [24] When determining which medications are placed on the plan's formulary and how the medications will be	• Plan documents do not contain information about the plan's formulary rules for determining coverage and tiering of medications. A Self-Compliance Tool developed by the federal government clarified that if a plan covered methadone	• In our review of the 2017 ACA Plans, we identified plans that excluded methadone for opioid addiction but covered methadone for the treatment of pain as having a possible parity violation. Per the Self-Compliance Tool's illustration, plans

[19] 45 C.F.R. § 146.136(c)(3)(v) (2011).
[21] 45 C.F.R. § 146.136(c)(4) (2011).
[22] United States Department of Labor. (2016). *FAQs about Affordable Care Act implementation part 34 and mental health and substance use disorder parity implementation.* Retrieved from https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf.
[23] United States Department of Labor. (2016). *FAQs about Affordable Care Act implementation part 34 and mental health and substance use disorder parity implementation.* Retrieved from https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf.
[24] 29 C.F.R. § 2590.712(c)(4)(ii)(B) (2010).

PARITY REQUIREMENT/ISSUE	ADDITIONAL DETAIL	EXAMPLES OF VIOLATIONS/POSSIBLE VIOLATIONS IDENTIFIED IN REVIEW
tiered, plans must use and apply the same factors for medications used for medical conditions and medications used for mental health and SUD treatment.	for the treatment of pain but excluded methadone for treatment of opioid addiction, it must "demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions."[25]	that provide disparate coverage for methadone treatment should carefully evaluate medical necessity criteria for methadone for opioid addiction treatment to ensure the exclusion does not violate MHPAEA.

[25] United States Department of Labor. *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA).* Retrieved from https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf.

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ADEQUATE BENEFIT COVERAGE FOR SUDs

To ensure that plans provide adequate coverage for evidence-based SUD care, plans should cover the critical SUD benefits that are medically necessary to prevent and treat addiction and should ensure that they do not impose harmful treatment limitations or burdensome requirements so that benefits are accessible. Below, we identify critical SUD benefits, best practices for benefit administration and examples of model language from our review of the 2017 EHB Benchmark Plans and 2017 ACA Plans.

REQUIREMENT/ ISSUE	THE CENTER'S RECOMMENDATIONS REGARDING BEST PRACTICES FOR BENEFIT ADMINISTRATION	SUD BENEFIT LANGUAGE FROM STATES' 2017 EHB BENCHMARK PLANS AND 2017 ACA PLANS
Define "substance use disorder" Plans use different terms to describe the condition, sometimes inconsistently, throughout plan documents. In our review, we consider smoking/tobacco use disorder to be an SUD.	• Plans should clearly define the terms used to describe SUDs and SUD treatment and use that terminology consistently throughout the plan documents. • Use precise clinical terminology and avoid the use of antiquated terminology such as "substance abuse" and "chemical dependency."	*"Substance use disorder" means an alcohol or drug problem that meets the diagnostic criteria for a "substance use disorder" in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V).* *"Tobacco addictions" are included in the SUD definition.*[26]
Critical SUD Benefits[27] Plans should cover the critical SUD benefits that are medically necessary to treat addiction, including:		

[26] Based on language from plan documents for plan sold in Michigan in 2017
[27] Please see our 2013 report, *EHB Recommendations for States*, in which we identified the critical SUD benefits that are medically necessary to treat addiction.

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• Routine screening and brief intervention in health care settings, including primary and urgent care	• Reimburse health care providers to use age-appropriate screening tools to routinely screen patients for all forms of substance use (tobacco, alcohol, illicit and prescription drugs) upon any contact with the health care system. • Screenings should include education for parents and their families about the health consequences of risky substance use, the disease of addiction and risk factors for both.	*"Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance: preventive counseling visits, risk factor reduction intervention, a structured assessment."*[28]
• Diagnostic evaluation, comprehensive assessment and treatment planning	• Reimburse specially trained health care professionals to perform comprehensive assessments to create the foundation for an effective treatment plan that is individualized and tailored to the patient.	*Benefits include the following services: diagnostic evaluations and assessment; treatment planning; and referral services*.[29]
• Stabilization/withdrawal management in inpatient and outpatient settings	• Stabilization/withdrawal management is often an important precursor to treatment, but on its own, it is not effective treatment for addiction. • Reimburse trained physicians and health care providers to provide stabilization/withdrawal management in the appropriate setting.	*"Substance abuse detoxification services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation." Detoxification services will be provided in an inpatient or outpatient setting, depending on medical necessity.* [30]

[28] Based on language from plan documents for plans sold in Iowa and Nebraska in 2017
[29] Based on language from the plan documents for the 2017 EHB benchmark plans for Kentucky and Wisconsin
[30] Based on language from the plan documents for Arizona's 2017 EHB benchmark plan

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• All FDA-approved pharmaceutical therapies • Evidence-based psychosocial therapies, such as: ○ Cognitive-behavioral therapy; motivational interviewing and motivational-enhancement therapy; community reinforcement approach; contingency management/motivational incentives; behavioral couples/family therapy; multidimensional family therapy; functional family therapy; and multisystemic therapy.	• Reimburse qualified health care professionals for delivering evidence-based addiction treatment. • Cover all FDA-approved medications designed to treat and manage addiction and office visits in the settings in which the medications are administered. • Plans should explicitly state in plan documents that methadone is covered in licensed Opioid Treatment Programs (OTPs) (see ACA Requirement to Cover Prescription Drugs above). • Plans should contract with a sufficient number of OTPs so members can access this treatment without unreasonable delay and to be consistent with state network adequacy standards for other primary care services. • Plans should cover counseling and behavioral therapies because they increase the efficacy of FDA-approved medications when used in combination with medication. Benefits should also include all required clinical services such as physician visits for medication management.	*We cover opiate replacement therapy* including methadone and buprenorphine treatment.*[31] *This includes office visits for medication management.* [32] *"Medication-Assisted Treatment visits include, but are not limited to, counseling and drug screening."*[33] ***We would encourage plans to use the term "medication-assisted treatment" or "medications for addiction treatment" instead of using antiquated terminology like "replacement therapy" or "maintenance therapy."**

[31] Based on language from the plan documents for Minnesota's 2017 EHB benchmark plan and plans sold in Minnesota in 2017
[32] Based on language from the plan documents for the District of Columbia's 2017 EHB benchmark plan
[33] Based on language from plan documents for plan sold in Massachusetts in 2017

REQUIREMENT/ ISSUE	THE CENTER'S RECOMMENDATIONS REGARDING BEST PRACTICES FOR BENEFIT ADMINISTRATION	SUD BENEFIT LANGUAGE FROM STATES' 2017 EHB BENCHMARK PLANS AND 2017 ACA PLANS
• Monitoring, support and continuing care ○ Ongoing, continuing support after treatment to help maintain treatment progress and avoid relapse. Includes therapy, medications and general medical care.	• Reimburse for ongoing pharmaceutical and psychosocial therapies, follow-up appointments to monitor progress and disease management services to promote patients' adherence to a treatment regimen and help patients manage their disease.	
Levels of Care[34] Plans should cover the critical SUD benefits in the following levels/settings of care:	• Plans should provide a clear description of the various levels of care that are covered and explain how the benefits are classified (i.e., inpatient or outpatient services). • We encourage plans to define the covered services by using the American Society of Addiction Medicine (ASAM) Criteria or another validated patient placement or level of care tool (hereinafter referred to as a "patient placement tool"). • Require provision of evidence-based treatment in all Levels of Care.	
• Outpatient treatment: Less than nine hours of evidence-based psychosocial therapy and education per week, delivered in a variety of locations (e.g., office or clinic).		*"Outpatient substance abuse services include services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program."*[35]

[34] As defined by *The ASAM Criteria - Treatment Criteria for Substance-Related, Addictive and Co-Occurring Conditions* (2013) (hereinafter, the ASAM Criteria).
[35] Based on language from the plan documents for Arizona's 2017 EHB benchmark plan

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• Intensive outpatient treatment: Services are similar to outpatient treatment but offered more frequently. Typically, for adults, nine or more hours of evidence-based psychosocial therapy and education per week and six hours or more per week for adolescents.		*Intensive Outpatient Program (IOP) – Intensive outpatient programs "must be available for a minimum of three (3) hours per day, three (3) days per week and must consist of, but not limited to, individual, group, and family therapy, medication evaluation and management services" and "must be available 24 hours a day 7 days per week for support of the patient. This program must provide substantial clinical support for patients who are either in transition from the hospital to an outpatient setting or at risk for admission to inpatient care or other higher levels of care."*[36]
• Day/Partial hospitalization: Outpatient treatment that offers services more frequently than IOP. Typically, 20 or more hours of evidence-based psychosocial therapy and education per week.		*Partial Hospital Program (PHP) – Partial Hospital programs "must be available for a minimum of five (5) hours per day five (5) days per week and must consist of, but not limited to, group, individual, and family therapy, medication evaluation and management services," and "must be available 24 hours a day 7 days per week for support of the patient. This program must provide substantial clinical support to patients who are either in transition from the hospital to an outpatient setting or at risk for admission to inpatient care or other higher levels of care."*[37]

[36] Based on language from the plan documents for Rhode Island's 2017 EHB benchmark plan
[37] Based on language from the plan documents for Rhode Island's 2017 EHB benchmark plan

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• Inpatient hospitalization: 24-hour, medically-supervised care in an acute care setting (i.e., a hospital).		
• A range of non-hospital residential treatment environments (including low-intensity, high-intensity, and population-specific) where services are provided 24 hours per day in a residential setting. Intensity of services differs depending on severity of the patient's condition.	• Require residential treatment facilities to be licensed or certified and accredited. • Require residential treatment facilities to have a physician serving as medical director.	*A residential treatment facility for SUD is "an institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for [SUD] residential treatment programs" and is credentialed by the plan or accredited by the Joint Commission or the Committee on Accreditation of Rehabilitation Facilities (CARF). "A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming" and "the medical director must be a physician."*[38]
Emergency	• Include explicit reference to behavioral health or SUD in the definition of an emergency condition. See Parity, Scope of Benefits requirement above	*"An **emergency** is a situation that is life threatening, involves severe pain, or can cause serious harm to your body or health if you do not receive treatment right away.*

[38] Based on language from plan documents for plans sold in Iowa and Nebraska in 2017

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		Examples of some types of emergencies are: Drug overdose."[39]
Patient Placement Tool Level of care and medical necessity determinations should be made pursuant to a scientifically validated patient placement tool (e.g., American Society of Addiction Medicine (ASAM) Criteria[40] or LOCADTR[41]).	• Rely on the tool as the clinical review criteria for prior authorization and medical necessity determinations and require providers to use the same tool.	*"Covered Services for treatment of addictive substance-related conditions will be based upon ASAM criteria (Treatment Criteria for Addictive Substance Related and Co-Occurring Conditions developed by the American Society of Addiction Medicine) when determining Medical Necessity and setting standards for levels of care for substance use disorder services."*[42] *"With respect to treatment of Substance Use Disorder the determination of Medically Necessary and Appropriate shall use an evidence-based and peer reviewed clinical review tool as designated in regulation by the Commissioner of Human Services."*[43]

[39] Based on language from plan documents for plan sold in Rhode Island in 2017
[40] Formally, *The ASAM Criteria - Treatment Criteria for Substance-Related, Addictive and Co-Occurring Conditions* (2013)
[41] Formally, Level of Care for Alcohol and Drug Treatment Referral, develop by the New York State Office of Alcoholism and Substance Abuse Services and Center on Addiction. Available at https://www.oasas.ny.gov/treatment/health/locadtr/index.cfm
[42] Based on language from plan documents for plan sold in New Hampshire in 2017
[43] Language from plan documents for plan sold in New Jersey in 2017

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Harmful Treatment Limitations To ensure services and medications are accessible, covered benefits should not be subject to overly restrictive treatment limitations or utilization management practices that restrict access to care and are not based on medical necessity or scientific evidence. Such limitations include:	• Plans should not use utilization management techniques that can impede or delay access to medications, such as prior and concurrent authorization requirements; limited authorization periods; and step therapy. Also, dosage limitations are not appropriate and can undermine treatment.	
• Prior Authorization. Requirements for prior authorization can add a further barrier to the already complex process of motivating patients to begin and stay in addiction treatment. They can also interfere with a provider's ability to develop an appropriate treatment plan, based on a clinical assessment.	• Plans should make prior authorization requirements as least restrictive as possible and presume that treatment is medically necessary when indicated by a patient placement tool.	*"When treatment is for Substance Use Disorder, we do not require Prior Authorization."*[44]
• Reimbursing only for short-term services. 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 and contingent on periodic evaluation of the patient's progress, based on a patient placement tool.	• Plans should not impose blanket limitations on number of allowed visits or lengths of stay.	

[44] Language from plan documents for plan sold in Massachusetts in 2017

REQUIREMENT/ ISSUE	THE CENTER'S RECOMMENDATIONS REGARDING BEST PRACTICES FOR BENEFIT ADMINISTRATION	SUD BENEFIT LANGUAGE FROM STATES' 2017 EHB BENCHMARK PLANS AND 2017 ACA PLANS
• Limits Based on Past Treatment Response. Placing limits on benefits based on past treatment response is not clinically appropriate and can be life endangering. Similarly, "fail first" policies, which require a patient to fail treatment at one level of care first, or to fail a specific therapy or medication before starting the recommended course of treatment, do not accord with best practices for treating SUDs.	• Plans should not impose these practices on SUD benefits.	
• Intoxication Exclusions/Uniform Individual Accident and Sickness Policy Provision Laws (UPPL) allow insurers in some states to deny coverage for injuries sustained by a person who was under the influence of alcohol or other drugs at the time of the injury. These laws deter health care providers from identifying and treating SUDs.	• These provisions sometimes appear in plan documents. There is no medical or ethical justification for these provisions – they should be eliminated.	**"Riots, War, Misdemeanor, Felony** Illness or injury sustained by a Member caused by or arising out of riots, war (whether declared or undeclared), insurrection, rebellion, armed invasion or aggression. Illness or injury sustained by a Member while in the act of committing a misdemeanor, or felony, or while engaging in an illegal occupation, unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition, mental health condition, or substance abuse disorder."[45]

[45] Language from plan documents for plan sold in Arizona in 2017

REQUIREMENT/ ISSUE	THE CENTER'S RECOMMENDATIONS REGARDING BEST PRACTICES FOR BENEFIT ADMINISTRATION	SUD BENEFIT LANGUAGE FROM STATES' 2017 EHB BENCHMARK PLANS AND 2017 ACA PLANS
• High Cost-Sharing. Cost is a significant barrier to SUD services, even for people who have insurance. High deductibles and daily or per admission co-payments may deter patients from seeking treatment.	• Plans should make out-of-pocket cost sharing as affordable as possible to encourage patients to seek SUD care.	*Plans impose no cost sharing*[46] *or no cost sharing after the member meets the deductible.*[47]
Co-Occurring Conditions 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.	• Reimburse for treatment of co-occurring conditions at all levels/settings of care**.**	*"Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained."*[48]
Facility Licensing Requirements State licensing and certification requirements vary significantly, and in some cases, addiction treatment facilities and programs may be entirely exempt.	• Plans should use their credentialing processes to require that addiction treatment facilities and programs are appropriately licensed and meet health plan standards that promote quality care.	*Inpatient care facilities "must be Licensed by the Department of Health and Human Services, Regulation and Licensure (or equivalent state agency), or accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO)."*[49] *"Day treatment, partial care, and Outpatient programs must be provided in a Hospital or facility which is Licensed by the Department of*

[46] Plans sold in Minnesota and South Dakota in 2017
[47] Plans sold in Nebraska and Virginia in 2017
[48] Based on language from the plan documents for Illinois's 2017 EHB benchmark plan
[49] Based on language from the plan documents for Nebraska's 2017 EHB benchmark plan

REQUIREMENT/ ISSUE	THE CENTER'S RECOMMENDATIONS REGARDING BEST PRACTICES FOR BENEFIT ADMINISTRATION	SUD BENEFIT LANGUAGE FROM STATES' 2017 EHB BENCHMARK PLANS AND 2017 ACA PLANS
		Health and Human Services Regulation and Licensure or accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF)."[50]
Notice of Parity Rights While not an explicit requirement, consumers are typically unaware of the Parity Act or the rights it affords. Yet, the enforcement framework is largely dependent on consumer complaints. As such, states should require plans to include information about the Parity Act in plan documents.	• In addition to ensuring that all benefits are administered in accordance with parity requirements, plans should also include language in plan documents about parity rights and inform members of the process to file parity complaints.	*"Your Rights under Mental Health and Addiction Parity Laws. This health plan provides coverage for medically necessary mental health and substance abuse treatment according to federal and state mental health parity laws. The financial requirements and treatment limits for your mental health or substance abuse coverage can be no more restrictive than those for your medical and surgical coverage. This means that the cost share amounts (a copayment, coinsurance, or deductible) for services to treat mental health and substance abuse will be the same or less than those for comparable medical and surgical services. Also, the review and authorization of services to treat mental health or substance abuse will be handled in a way that is comparable to the review and authorization of medical and surgical services." If you believe that [the insurer] is not compliant with these mental health parity laws, you can make a complaint to the [insert appropriate state agency and include specific instructions for filing a complaint in writing, electronically and by telephone].*[51]

[50] Based on language from the plan documents for Nebraska's 2017 EHB benchmark plan
[51] Based on language from the plan documents for Massachusetts's 2017 EHB benchmark plan