The National Center on Addiction and Substance Abuse

# UNCOVERING COVERAGE GAPS:

# A REVIEW OF ADDICTION BENEFITS IN ACA PLANS

JUNE 7, 2016

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# ACCOMPANYING STATEMENT BY SAMUEL A. BALL, PHD, PRESIDENT AND CHIEF EXECUTIVE OFFICER

Addiction and substance abuse are the number one preventable health problem in the United States, affecting millions of Americans. Despite the gravity and scope of the problem, only about 10 percent of people who need addiction treatment receive it. When people cannot access treatment, it can lead to disability, death, and a range of other health and social consequences. Providing effective treatment is a win-win: not only can it save lives, it can reduce long-term health care costs for insurers.

Historically, health insurance plans have offered limited benefits for addiction – covering fewer services at higher cost with more restrictions and limitations. The Affordable Care Act (ACA) aims to correct this injustice by expanding access to substance use disorder (SUD) treatments. The law mandates coverage of SUD services as an Essential Health Benefit (EHB) and requires that SUD benefits be provided at parity with comparable medical/surgical benefits. In essence, the ACA requires insurance companies to pay for addiction treatment the same way they cover treatment for other chronic diseases, like diabetes or cancer.

Unfortunately, the ACA did not define which SUD benefits must be covered. Instead, each state selects an EHB-benchmark plan to serve as a template. The benefits offered in the EHB-benchmark plan become the minimum level of SUD coverage that ACA plans sold in that state must offer. Predictably and regrettably, decisions on what coverage to offer are not informed by what research shows to be the amount and duration of treatment needed to help addicted people get on a path of recovery. A "minimum level of coverage" almost never translates into an effective level of service for what are often very complex and chronic disorders.

The National Center on Addiction and Substance Abuse undertook an extensive review of the 2017 EHB-benchmark plans to evaluate the SUD benefits offered in each state. The results are disheartening. None of the plans cover the full range of necessary and effective SUD benefits without imposing harmful treatment limitations. For example, not one plan covers every FDA-approved drug to treat opioid addiction. Two-thirds of the plans violate at least one of the ACA's requirements related to the coverage of addiction treatment. Many plans contain vague descriptions of their SUD benefits, making a comprehensive analysis of compliance and benefit adequacy impossible.

In the past decade, research on addiction has made tremendous strides - uncovering the neurological basis of addiction and identifying an array of effective treatments. However, patients are not reaping the benefits of this progress. This report finds that insurance coverage still falls far short for many people – limiting their access to life-saving care.

Our nation is in the throes of an opioid epidemic that has become the leading cause of death for youth and is driving the rising death rate among other age groups. To protect our children and their families from the devastating harms and losses caused by untreated addiction, we must use every tool at our disposal to intervene and provide the right type, intensity, and duration of care. Patients should never be denied access to life-saving care and should not have to battle with their insurance companies over issues that limit or create barriers to receiving professional help. The absence of sufficient coverage for medications to treat opioid addiction is particularly alarming given the number of people dying or suffering on a daily basis. This kind of health care discrimination would never be tolerated for any other life threatening disease.

Comprehensive insurance coverage for addiction, alone, will not eradicate the opioid crisis – but it is essential. We also need more providers who are trained to offer effective treatments for addiction, greater funding for research and treatment, higher reimbursement rates for care, expanded prevention and recovery efforts, and better prescription drug monitoring programs.

This report highlights the coverage gaps that remain in ACA plans across the US and provides suggestions for how to resolve them. The National Center on Addiction and Substance Abuse is calling on states to ensure that insurance plans available to their residents comply with the law and offer comprehensive coverage of effective addiction treatments. Until we commit to fully treating addiction as a disease, patients and their families will continue to suffer needlessly.

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The National Center on Addiction and Substance Abuse's "Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans" was prepared by Lindsey Vuolo, JD, MPH, Associate Director of Health Law and Policy with the assistance of Emily Feinstein, JD, Director of Health Law and Policy. Many current and former Center staff members contributed to the paper, but we would like to especially thank Tiffany John, LMSW, Max Dorfman, MA and David Man, PhD, MLS, who assisted with the data collection and references for the paper. Linda Richter, PhD, Director of Policy Research and Analysis provided thoughtful feedback on the content. Andrea Roley, BA, Michelle Conley, MIPH, and Elizabeth Mustacchio, MBA, managed the communications, marketing and distribution activities. Jennie Hauser provided invaluable administrative support.

While many contributed to this effort, the opinions expressed herein are the sole responsibility of The National Center on Addiction and Substance Abuse.

# TABLE OF TERMS

| Term | Definition |
|---|---|
| Affordable Care Act (ACA) | The federal health insurance reform law passed by President Obama in 2010. The ACA requires certain health plans to cover 10 categories of benefits, called Essential Health Benefits (EHB). |
| ACA Plans | The individual and small group market health plans that are subject to the ACA's requirements, including the EHB requirement and parity. |
| Aggregate lifetime dollar limit | A dollar limit on the total amount of health care services the plan will pay for a specific patient. For example, a patient's plan has a $5,000,000 maximum lifetime limit on benefits. Once the plan has paid this amount for the patient's health care, the health plan will no longer pay for any health care services for the patient. |
| Benchmark approach | The process used by states to define which Substance Use Disorder (SUD) services ACA Plans in their state must cover. States define the SUD services by selecting an existing employer plan to serve as the reference plan (i.e., the EHB-benchmark plan). At a minimum, ACA Plans must cover the SUD benefits in the state's EHB-benchmark plan. |
| Classification of benefits | Mental Health Parity Addiction and Equity Act of 2008 (MHPAEA) requires ACA Plans to put SUD benefits into one of the following six classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. |
| Coinsurance | A financial (cost-sharing) requirement imposed by a health plan whereby a patient must pay a certain percentage of the total cost of health services. For example, a 30 percent coinsurance means that if a bill for health services is $1,000, then the health plan will pay $700 and the patient must pay $300. |
| Copayment (aka copay) | A financial (cost-sharing) requirement imposed by a health plan whereby a patient must pay a set amount when receiving health services (e.g., $25 per doctor's visit or $100 per admission to a hospital). |
| Cost-sharing | The amount a patient has to pay for health services that are covered by the health plan (i.e., a co-pay, coinsurance or deductible), also called a financial requirement. |
| Cumulative financial requirements | Cost-sharing requirements (e.g., deductibles or out-of-pocket maximums) that accumulate over time. ACA Plans cannot apply cumulative financial requirements to SUD services only. For example, a health plan cannot have an annual deductible for outpatient SUD services unless it also applies to outpatient medical services. |
| Cumulative quantitative treatment limitations | Treatment limitations that are measured over time. For example, annual or lifetime day or visit limits. In ACA Plans, any annual or lifetime treatment limitations must apply to both SUD services and medical services. For example, a health plan can have a 30 day outpatient visit limit for all outpatient health care services, but it cannot impose a 30 day outpatient visit limit for SUD services only. |
| Deductible | A financial (cost-sharing) requirement imposed by a health plan whereby a patient must pay a specified amount out-of-pocket before the health plan will pay any money for health services. For example, a patient who has a $500 deductible must pay for all health services up to $500 before the health plan begins to pay for claims. |
| EHB-benchmark plan | The final reference plan that defines the EHB services that must be covered by, and serves as a template for, ACA Plans sold in the state. ACA Plans must, at a minimum, provide benefits that are substantially equal to the benefits in the state's EHB-benchmark plan. |
| Essential Health Benefits (EHB) | The 10 categories of benefits (e.g., mental health and substance use |

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| | disorder services including behavioral treatment, preventive services, prescription drugs) that ACA Plans must cover. |
| Formulary | The list of prescription drugs that are covered by a health plan. |
| Individual plans | Health insurance plans not sponsored by an employer or the government. These plans are purchased directly by individuals (typically on the Marketplaces or Exchanges) and must comply with the ACA (including the EHB requirement). |
| Large group plans | Health insurance plans offered to employees of companies with more than 100 employees. This includes state employee, federal employee and HMO plans. |
| Medical necessity | A practice where the health plan conducts a review to determine whether it will pay for health care services. Typically, a doctor submits medical record information to the health plan to prove that the recommended treatment is medically necessary. A health plan will not pay for health care services unless the plan's medical experts agree that the care is necessary, based on medical standards of care. |
| Mental Health Parity Addiction and Equity Act of 2008 (MHPAEA) | The federal law that requires health plans to offer mental health/SUD benefits that are equal to medical/surgical benefits. ACA Plans subject to the EHB requirement must also comply with MHPAEA. |
| Non-quantitative treatment limitations (NQTLs) | The different review practices (also called utilization management) used by health plans to determine whether the plan will pay for health care services recommended by a doctor, including medical necessity and prior authorization. |
| Opioid Treatment Program | A program or clinic that is federally-certified to use methadone or buprenorphine to treat individuals with opioid use disorder. |
| Out-of-pocket maximum | The maximum amount a patient will have to pay out-of-pocket for health services per year. For example, a patient has a $1,500 out-of-pocket maximum for a health plan that started on January 1. As of September, the patient has paid $1,500 in copayments, coinsurance and the deductible. The patient will no longer have to pay any out-of-pocket costs for services covered by the plan until next January. |
| Parity | The requirement that health plans offer benefits for mental health conditions and SUDs that are equal to the benefits for medical conditions. |
| Prior authorization | A practice where a health plan requires the patient and/or doctor to obtain permission before receiving health care services. For example, a doctor or patient contacts the health plan to request permission for the patient to go to residential treatment prior to going to that facility. Often a medical necessity review will be conducted to determine whether the request for the service will be authorized. Failure to obtain prior authorization when it is required often means the health plan will not pay for the services that were received. |
| Quantitative treatment limitations (QTLs) | Treatment limitations expressed in numbers (e.g., 50 visit limit per year, $500 co-pay). |
| Small group plans | Health insurance plans offered to employees of companies with less than 100 employees. These plans are subject to the ACA (including the EHB requirement). |
| Substance use disorder (SUD) | 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) |
| SUD benefits | The specific health care services and medications an insurance plan states it will pay for related to the treatment of an alcohol or drug problem. In this paper, we considered tobacco/smoking cessation services to be a SUD benefit. |

# INTRODUCTION

The Affordable Care Act (ACA) holds great promise for expanding access to substance use disorder (SUD) treatment. The law provides insurance coverage to millions of previously uninsured individuals, mandates coverage of SUD services as an Essential Health Benefit (EHB), and requires that SUD benefits be provided at parity with comparable medical/surgical benefits. Despite the law's promise, its requirements have not resulted in adequate coverage of evidence-based SUD services and medications by health insurance plans.

One reason is that the law did not define which SUD benefits must be covered. Instead, each state defines the SUD benefits it wants its plans to cover by identifying an EHB-benchmark plan. The benefits offered in the state's EHB-benchmark plan serve as a template, establishing the minimum level of coverage for most individual and small group health insurance plans in the state.

States recently selected new EHB-benchmark plans for 2017. The National Center on Addiction and Substance Abuse reviewed each state's 2017 EHB-benchmark plan to determine whether the plan: (1) satisfies the ACA's requirements regarding coverage of SUD benefits; (2) complies with parity requirements; (3) provides adequate care for SUDs by covering the full range of critical SUD benefits without imposing harmful limitations; and (4) provides enough information to sufficiently evaluate compliance and adequacy of benefits. Our findings suggest that states are not fully complying with the ACA's requirements for coverage of SUD benefits, including parity, and that the 2017 EHB-benchmark plans provide inadequate coverage for SUD benefits. Specifically,

I. Over two-thirds of the plans do not comply with the ACA's requirements for coverage of SUD benefits.
II. Eighteen percent of the plans violate parity requirements; 31 percent of the plans contain possible parity violations.
III. None of the plans provide comprehensive coverage for SUDs by covering the full array of critical benefits without harmful treatment limitations; the most frequently excluded or not explicitly covered benefits are residential treatment and methadone maintenance therapy.
IV. Plan documents for 88 percent of the 2017 EHB-benchmark plans lack sufficient detail to fully evaluate compliance with the ACA and/or the adequacy of SUD benefits.

In order to fulfill the ACA's intent of dramatically expanding access to SUD treatment, states should revise their EHB-benchmark plans to comply with the law and ensure comprehensive coverage of evidence-based SUD benefits without harmful treatment limitations. This will not only have a tremendous positive impact on patients seeking medically-necessary and life-saving care, it can also be expected to decrease costs for the health plans in the long-term.

# BACKGROUND

## *ACA Requirements for Coverage of SUD Benefits*

The Affordable Care Act (ACA) requires most individual and small group health plans (ACA Plans) to cover 10 categories of benefits, known as the Essential Health Benefits (EHB).[1] One of the EHB categories is mental health and substance use disorder (SUD) services including behavioral health treatment, which must be covered at parity with comparable medical/surgical services.[2] ACA Plans are also required to cover certain SUD benefits under the preventive services and prescription drugs EHB categories.[3] The EHB requirement, which became effective on January 1, 2014, prohibits plans from imposing lifetime and annual dollar limits on SUD benefits.[4] The EHB requirement was expected to correct historically limited benefit coverage in the small-group and individual markets generally, and for SUD services in particular.[5] Such services have been excluded more frequently, covered less adequately, or subjected to more restrictive limits and requirements than other health care services.[6]

### Preventive Services

Under the ACA, plans must cover an array of preventive health services without cost sharing. The list of mandated benefits includes:

- Preventive care services for adults that receive an "A" or "B" grade in the United States Preventive Services Task Force's (USPSTF)[*] current recommendations (e.g., blood pressure, cholesterol, diabetes, tobacco, alcohol and cancer screenings), and
- Preventive care services and screenings for infants, children, and adolescents that are recommended in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)[†] (e.g., developmental/behavioral assessments, lead screening, alcohol and drug use assessments, immunizations).[7]

#### *Tobacco Screening and Cessation*

Tobacco cessation for adults, including behavioral and pharmacotherapy interventions, and tobacco cessation for pregnant women, including behavioral interventions, have an "A" grade from the USPSTF.[8] Pursuant to guidance issued by the Department of Labor, ACA Plans must cover screening for tobacco use and at least two tobacco cessation attempts per year for adults.[9] Coverage for one cessation attempt includes:

- Four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization, and
- One 90-day treatment regimen, prescribed by a physician, of any Food and Drug Administration (FDA)-approved tobacco cessation medication (including prescription and over-the-counter) without prior authorization.[10]

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[*] The United States Preventive Services Task Force (USPSTF) is a panel of experts that reviews the scientific evidence related to clinical preventive health care services for adults and develops recommendations regarding their use in primary care. An "A" grade means there is a "high certainty" that the net benefit of the screening is substantial while a "B" grade means the net benefit of the rating is moderate or moderate to substantial.
U.S. Preventive Services Task Force. (2014). *Grade Definitions*. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions.

[†] The Health Resources and Services Administration (HRSA) promotes the Bright Futures recommendations published by the American Academy of Pediatrics. American Academy of Pediatrics. (2016). *Bright Futures*. Retrieved from https://brightfutures.aap.org/Pages/default.aspx.

- There are currently seven FDA-approved tobacco cessation medications: Zyban® (bupropion), Chantix® (varenicline), and five forms of nicotine replacement therapy (NRT), including patch, gum, lozenge, nasal spray and inhaler.

*Alcohol and Drug Use Screening*

Screening for alcohol and drug use is a critical tool for preventing addiction and brief interventions are a low cost and effective way to address risky substance use. Assessments help determine a course of treatment for patients identified as having or at risk for developing a SUD.

ACA Plans must cover:

- Screening for alcohol misuse and brief behavioral counseling interventions to reduce alcohol misuse in adults.[11]
- Both alcohol and drug use assessments for adolescents aged 11–21 years.[12]

Prescription Drugs

One of the 10 EHB categories is prescription drugs, which includes medications to treat addiction. ACA Plans must cover at least one drug in every therapeutic category and class listed in the United States Pharmacopeia (USP) Medicare Model Guidelines.[*,13]

There is only one therapeutic category for SUD medications: "Anti-Addiction/Substance Use Treatment Agents." Within this category there are four "classes" of drugs; the drugs in each class are:[14]

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 naltrexone (e.g., Vivitrol®, Revia®, Depade®)

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

Methadone, an FDA-approved and effective medication for the treatment of opioid addiction, is not included in the USP Medicare Model Guidelines because methadone is excluded from Medicare prescription drug (Part D) coverage.[15] The Medicare statute requires Part D prescription drugs to be dispensed upon a prescription at a pharmacy.[16] Methadone cannot be dispensed at a pharmacy; under federal law it can only be dispensed by specially-licensed Opioid Treatment Programs.[17] The exclusion of methadone by Medicare Part D carries over to the ACA Plans because of the reliance on the USP Medicare Model Guidelines. It is unclear whether the authors of the ACA intended to exclude methadone from the prescription drug EHB requirement.

[*] Or, the same number of drugs in each USP category and class in the state's EHB-benchmark plan.

Substance Use Disorder (SUD) Services

Most SUD benefits fall into the EHB category, "mental health and substance use disorder services including behavioral health treatment." Neither the ACA nor the supporting regulations define which SUD services must be covered by ACA Plans. Instead, the U.S. Department of Health and Human Services (HHS) adopted a "benchmark approach" that allows each state to adopt its own definition.[18]

The benchmark approach requires each state to select an existing employer-sponsored plan (either a small-group, state employee, federal employee or HMO plan)[*] to serve as the EHB-benchmark plan.[19] The EHB-benchmark plan must cover each of the 10 EHB categories and meet standards for non-discrimination and balance.[20] Benefit design cannot discriminate based on age, expected length of life, disability, medical dependency, quality of life, or other health conditions; or, on the basis of race, color, national origin, sex, gender identity or sexual orientation.[21] EHB categories must be properly balanced so that benefits are not unduly weighed toward any category.[22]

The purpose of the state's EHB-benchmark plan is to define the EHB benefits that all ACA Plans offered in the state must cover and to serve as the template for those plans.[23] Therefore, the EHB-benchmark plan dictates the minimum level of SUD benefits that must be offered by the ACA Plans in each state.

## *Parity Requirements*

ACA Plans must comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[24] In order to ensure that people with mental health disorders and addiction receive appropriate health care, MHPAEA requires ACA Plans to offer mental health/SUD benefits that are on par with medical/surgical benefits. For example, Patient A suffers from Type 2 Diabetes. His insurance plan covers the following benefits to treat his disease: treatment in the emergency department for diabetic shock (emergency care); a foot amputation (inpatient hospital care); follow up appointments with his doctor (outpatient service); and medications (prescription drug benefit). If this same patient also suffers from an opioid use disorder, parity would require coverage of a comparable scope of benefits, such as: treatment in the emergency department for opioid overdose (emergency care); detoxification and treatment in the hospital (inpatient hospital care); follow up appointments at a clinic (outpatient services); and medications for his opioid dependence, such as methadone or buprenorphine (prescription drug benefit).

In 2014, our Center issued a Guide to Implementing and Enforcing MHPAEA Requirements for Addiction Prevention and Treatment Benefits, in which we provided a detailed description of how MHPAEA applies to SUD benefits.

MHPAEA ensures parity among benefits by applying the following requirements and prohibitions:

Comparable Scope of Benefits

- ✓ If a plan offers SUD benefits in at least one classification of benefits (e.g., inpatient, outpatient, emergency care, prescription drugs), then it must offer SUD benefits in every classification where medical/surgical benefits are offered.[25] For example, an insurance plan cannot cover the full range of benefits for diabetes (such as inpatient hospital care, dialysis treatment, rehabilitation in a skilled nursing facility, outpatient follow up visits and insulin), but only cover SUD treatment in an outpatient clinic.

[*] States were directed to select an EHB benchmark plan from among 10 options: any of the three largest small-group market plans or state employee health benefit plans in the state; any of the three largest national Federal Employees Health Benefit Program (FEHB) plans; or the state's largest commercial Health Maintenance Organization (HMO). Centers for Medicare & Medicaid Services. (2011). *Essential Health Benefits Bulletin*. Retrieved from https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

- ✓ 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.[26] Plans that cover intermediate SUD services must cover such services similarly to comparable intermediate medical services (e.g., home health care, skilled nursing facilities).[27]

Equivalent Financial Requirements and Treatment Limitations

- ✓ Plans cannot place financial requirements (e.g., co-pays, deductibles) or quantitative treatment limitations (QTLs) (e.g., 30 office visits per year) on SUD benefits that are more restrictive than those placed on comparable medical/surgical benefits.[28]
    - The MHPAEA regulations provide a test: Financial requirements and QTLs cannot be more restrictive than the "predominant" financial requirements and treatment limitations that apply to "substantially all" medical/surgical benefits in the same classification.[29] The MHPAEA regulations define "predominant" as more than half and "substantially all" as more than two-thirds. Applying the "predominant and substantially all" test requires information not typically provided in plan documents: the classification (e.g., inpatient/outpatient) 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 medical/surgical benefits in that classification.[30]

- ✓ Non-quantitative treatment limitations (NQTLs) (e.g., medical necessity review, prior authorization requirement) placed on SUD benefits must be "comparable to" and "applied no more stringently than" NQTLs placed on medical/surgical benefits (i.e., the plan must use the same procedures for creating and applying NQTLs) in the same classification.[31] For example, a plan can require prior authorization for all inpatient medical/surgical and SUD benefits. If, in practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days at a time (after which a treatment plan must be approved by the plan), the plan cannot routinely approve only one day at a time for inpatient SUD benefits, because that would violate the "applied no more stringently" rule.
    - Applying the NQTL test also requires information not typically provided in plan documents.
    - The MHPAEA interim final regulations contained an exception to the NQTL requirements that allowed for variation "to the extent that recognized clinically appropriate standards of care may permit a difference." In response to public comments, HHS removed this exception from the final regulations.[32]

- ✓ Cumulative financial requirements (e.g., deductibles, out-of-pocket maximums) and QTLs (e.g., lifetime limits) for SUD benefits cannot accumulate separately from medical/surgical benefits when such benefits are in the same classification.[33] For example, a plan that imposes an annual $250 deductible on all medical/surgical benefits cannot impose a separate annual $250 deductible on SUD benefits.

- ✓ Finally, MHPAEA prohibits plans from imposing an annual dollar limit on SUD benefits unless an annual dollar limit also applies to medical/surgical benefits.[34]

In order for reviewers to evaluate parity among SUD and medical/surgical benefits, plan documents must provide detailed information about the specific SUD services and medications that are covered and applicable cost-sharing requirements and treatment limitations.

The insurance plans selected to serve as the states' 2017 EHB-benchmark plan were not subject to MHPAEA; however, any future ACA Plans that are modeled on the 2017 EHB-benchmark plans must

comply with MHPAEA.[*] The Centers for Medicare and Medicaid Services (CMS) recognized that this could create problems because non MHPAEA-compliant EHB-benchmark plans will not provide a sufficient template for any future ACA Plans. CMS acknowledged that it would have been easier for issuers if the state chose an MHPAEA-compliant plan for the 2017 EHB-benchmark plan but that time constraints precluded states from doing so.[35]

## *Evidence-Based SUD Care*

Critical SUD Benefits

In 2013, we issued a report, EHB Recommendations for States, to promote the coverage of evidence-based care in the EHB-benchmark plans. Our recommendations identified the critical SUD benefits that are medically necessary to prevent and treat addiction. These critical addiction-related health benefits are necessary for providing quality care and should be covered by all EHB-benchmark plans:[36]

*Routine Screening and Brief Intervention (SBI) in Health Care Settings, Including Primary and Urgent Care*

Patients should be routinely screened, with age-appropriate screening tools, for all forms of substance use—including tobacco, alcohol, illicit drugs and controlled prescription drugs—upon any contact with the health care system. 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.

For those who screen positive for risky substance use or who have a very mild SUD (sometimes called substance abuse), a brief intervention (typically involving motivational interviewing techniques and substance-related education) can be an effective, low-cost intervention.[37]

*Diagnostic Evaluation, Comprehensive Assessment and Treatment Planning*

For individuals showing signs of addiction, the first step is to determine the clinical diagnosis. If an individual is diagnosed with a SUD, a specially-trained health care professional should perform a comprehensive assessment to determine:

- Severity of the addiction.
- Any other medical (including mental health) conditions.
- Potential for complications related to withdrawal.
- Presence of other factors (individual and social) related to substance use that may affect treatment.

Other tests, such as urine, breath, saliva, hair, or blood tests, may be used to supplement the comprehensive assessment. 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.

[*] MHPAEA became effective on the "first day of the first plan year after July 1, 2014", which for most plans was January 1, 2015. 78 Fed. Reg. 68,240, 68,253 (Nov. 13, 2013). Because the plans selected to serve as the 2017 EHB-benchmark plans were created prior to this effective date, they did not have to comply with MHPAEA.

*Stabilization/Withdrawal Management*

As a precursor to treatment, the patient's condition should be stabilized via cessation of substance use, including medically-supervised withdrawal management (detoxification) when necessary.

Detoxification may include:

- Gradually reducing the dose if the patient is addicted to prescription drugs.
- Easing withdrawal symptoms with medication.
- Other medical and social supports to ensure safety and comfort.
- Beginning long-term medication for addiction to alcohol or opioids.

A trained physician or health care provider should determine the appropriate setting (e.g., patient's home, physician's office, non-hospital treatment facility, hospital, intensive outpatient/partial hospitalization program) for detoxification.

Once stabilized, patients should receive addiction treatment immediately on site or through facilitated referral. Stabilization/withdrawal management alone is not an effective treatment for addiction. Providing ongoing treatment is critical to managing the condition and preventing further health and social consequences.[38]

*Addiction Treatment*

Qualified health care professionals should deliver evidence-based addiction treatment, accompanied by treatment for co-occurring conditions. Depending on the type and severity of the patient's addiction and general health status, 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 should also be covered.

- **Pharmaceutical Therapies**. Pharmaceutical therapies are an effective, and for some conditions, critical component of addiction treatment.[39]

  The EHB requirement to cover at least one drug in each United States Pharmacopeia (USP) category and class is insufficient for SUD treatment. First, the USP Medicare Model Guidelines used to determine the categories and classes exclude methadone. Second, the drugs in each class are not interchangeable. There are currently three FDA-approved medications to treat opioid addiction – methadone, buprenorphine (alone or in combination with naloxone, as in Suboxone), and naltrexone (or its injection form, Vivitrol) – which are used in medication-assisted treatment (MAT). Methadone and buprenorphine deliver an oral, longer-acting, and safer version of opioids to help manage opioid addiction, withdrawal symptoms, cravings, and prevent overdose by blocking or occupying opioid receptors. Naltrexone, which is taken daily, or Vivitrol, a once monthly shot, blocks opioid receptors completely, preventing any effect of opioids, including intoxication or overdose. Buprenorphine/naloxone combination therapy is an abuse deterrent formulation of buprenorphine; the naloxone component reduces rewarding effects if the drug is crushed for misuse or abuse.[40] Each medication has a different mechanism of action, different side effects, different regulatory restrictions and different protocols for administration. The medications are typically prescribed or administered in distinct health care settings. To ensure proper treatment, patients must have access to all of these medications and the settings in which they are administered, so they can take the one that is most effective for them.

  All FDA-approved medications designed to treat and manage addiction should be covered by the EHB-benchmark plans. Benefits should include all clinical services required for patients to access these medications, 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 a medication modality (e.g., methadone 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.[41] Psychosocial therapies must be tailored to individual patient characteristics, such as age, gender, culture, and sexual orientation. Evidence-based psychosocial therapies include, but are not limited to:

    1. Cognitive-behavioral therapy
    2. Motivational interviewing and motivational-enhancement therapy
    3. Community reinforcement approach
    4. Contingency management/motivational incentives
    5. Behavioral couples/family therapy
    6. Multidimensional family therapy
    7. Functional family therapy
    8. Multisystemic therapy

- **Level/Setting and Length of Treatment.** Different levels of care offer different treatment types and intensities of services.[42] Covering the full range of levels of care is necessary so that treatment can be tailored to meet the specific needs of the patient, an important component of effective care. Unconditionally excluding a level of care limits a patient's treatment options and could lead to worse outcomes.[43]

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

    1. Outpatient treatment
    2. Intensive outpatient treatment
    3. Day/Partial hospitalization
    4. Inpatient hospitalization
    5. A range of non-hospital residential treatment environments (including low-intensity, high-intensity, and population specific)

    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. Addiction treatment services and levels/setting of care should allow for concurrent treatment of all health conditions.[44]

*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 they are for persons with other chronic conditions like diabetes or hypertension. Follow-up appointments to monitor progress and disease management services to promote patients' adherence to a treatment regimen and management of their disease contribute to positive outcomes. As is the case with other chronic diseases (e.g., various cancers), periodic follow-up visits are necessary to monitor the patient's status.

Harmful Treatment Limitations

To ensure treatments are accessible, covered benefits should not be subject to overly restrictive treatment limitations or utilization management practices (e.g., prior authorization or medical necessity review), high co-payments or other limitations that restrict access to care. Plans should not impose treatment limitations that are not based on medical necessity or scientific evidence.

*Prior Authorization*

Utilization management practices, such as requirements for prior authorization, can add a further barrier to the already complex process of motivating patients to begin and stay in treatment. Addiction affects the parts of the brain associated with motivation, decision making, risk/reward assessment and impulse control; therefore, engaging and retaining patients in treatment can be difficult. Because a patient's window of motivation to engage in treatment may be narrow and shifting, imposing delays in the initiation of care can result in a failure to follow up or return for subsequent appointments. Failing to retain patients can result in serious consequences for the patient, including returning to substance use, medical complications, overdose and death.[45] Excessive prior authorization requirements for SUD benefits are not clinically appropriate, particularly given the waxing and waning of motivation to enter treatment that often characterizes people suffering with the disease of addiction.

*Level of Care Exclusions*

Tailoring treatment to the specific needs of the individual patient is an essential component of effective care and can only be achieved when different levels of care are available. For example, when residential care is not available to the patient, the patient may seek care at an outpatient setting where that patient's needs may not be addressed adequately, or at a hospital inpatient setting where unnecessary care may be provided at a higher cost.[46] Allowing for access to a range of levels of care, including inpatient, outpatient and intermediate services, 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.

*Reimbursing Only for Short-term or Acute Care 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. Blanket limitations on allowed visits or lengths of stay do not accord with best practices for treating cases of addiction that are chronic and relapsing. Further, reimbursing only for short-term or acute care services is neither clinically appropriate nor consistent with the robust scientific evidence indicating that longer durations of treatment are more effective than acute or short-term treatments.

If a health plan only pays for detoxification, it is only paying to ease withdrawal symptoms, 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 detoxification and possibly requiring higher levels of care, leading to increased costs for the health plan.[47]

*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.

*Uniform Individual Accident and Sickness Policy Provision Laws*

Uniform Individual Accident and Sickness Policy Provision Laws (UPPL) allow insurers 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. There is no medical or ethical justification for these provisions – they should be eliminated.

*High Cost Sharing*

Finally, cost is a significant barrier to SUD services, even for people who have insurance.[48] High daily or per admission co-payments may deter patients from seeking treatment. Even if these requirements are in parity with cost-sharing requirements for comparable medical services, such high cost-sharing requirements impede access to care.

## *Public Review of 2017 EHB-Benchmark Plans*

In 2015, the Centers for Medicare and Medicaid Services (CMS) announced that states could select a new EHB-benchmark plan for 2017, based on a plan offered in 2014.[49] The ACA requires notice and the opportunity for public comment for any revisions or modifications to EHB.[50] On August 28, 2015, CMS posted a list of the proposed 2017 EHB-benchmark plans and supporting plan documents for each state and the District of Columbia to its website and solicited public comments.[51] CMS encouraged the public to review the proposed EHB-benchmark plans for EHB compliance and adequacy of benefits in the EHB categories.[52] The proposed EHB-benchmark plans were adopted as final in December 2015.[*] We reviewed any final plans that were posted through April, 2016.

[*] In its Notice of Benefit and Payment Parameters for 2017, HHS announced that the final 2017 EHB-benchmark plans were posted to CMS' website. 80 Fed. Reg. 75,488, 75,517 (Dec. 2, 2015). While CMS has not disclosed the date on which the final plans were selected, based on information contained on its website and in the Notice of Benefit and Payment Parameters for 2017, it must have been done between the close of the comment period, September 30, 2015, and the publication date for the 2017 Notice of Benefit and Payment Parameters, December 2, 2015.

# RESULTS OF THE REVIEW

The National Center on Addiction and Substance Abuse reviewed each state's 2017 EHB-benchmark plan to evaluate SUD benefits and determine whether the plan: (1) satisfies the ACA's requirements regarding coverage of SUD benefits; (2) complies with parity 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 its plan documents to sufficiently evaluate compliance and adequacy of benefits. Our review reveals extensive noncompliance with the ACA's requirements and inadequate coverage of SUD benefits among the 2017 EHB-benchmark plans.

The ACA requirements impact the roughly 12.7 million people who purchase their insurance through the Marketplaces or Exchanges.[53] This report does not look at insurance coverage for people outside these plans, including people who receive insurance through Medicaid or their employer.

## *Compliance with ACA Requirements for Coverage of SUD Benefits*

Over Two-Thirds of the 2017 EHB-Benchmark Plans Do Not Comply with the ACA's Requirements for Coverage of SUD Benefits

The 2017 EHB-benchmark plans are existing policies that were offered in 2014 and were subject to the ACA's requirements for coverage of SUD benefits.[54] Nevertheless, a review of the 2017 EHB-benchmark plans reveals that over two-thirds of these plans contain facial (obvious) violations of the ACA (see *ACA Violations* map on next page).[*]

1. *Fifty percent of the 2017 EHB-benchmark plans violate the EHB requirement for tobacco cessation coverage*

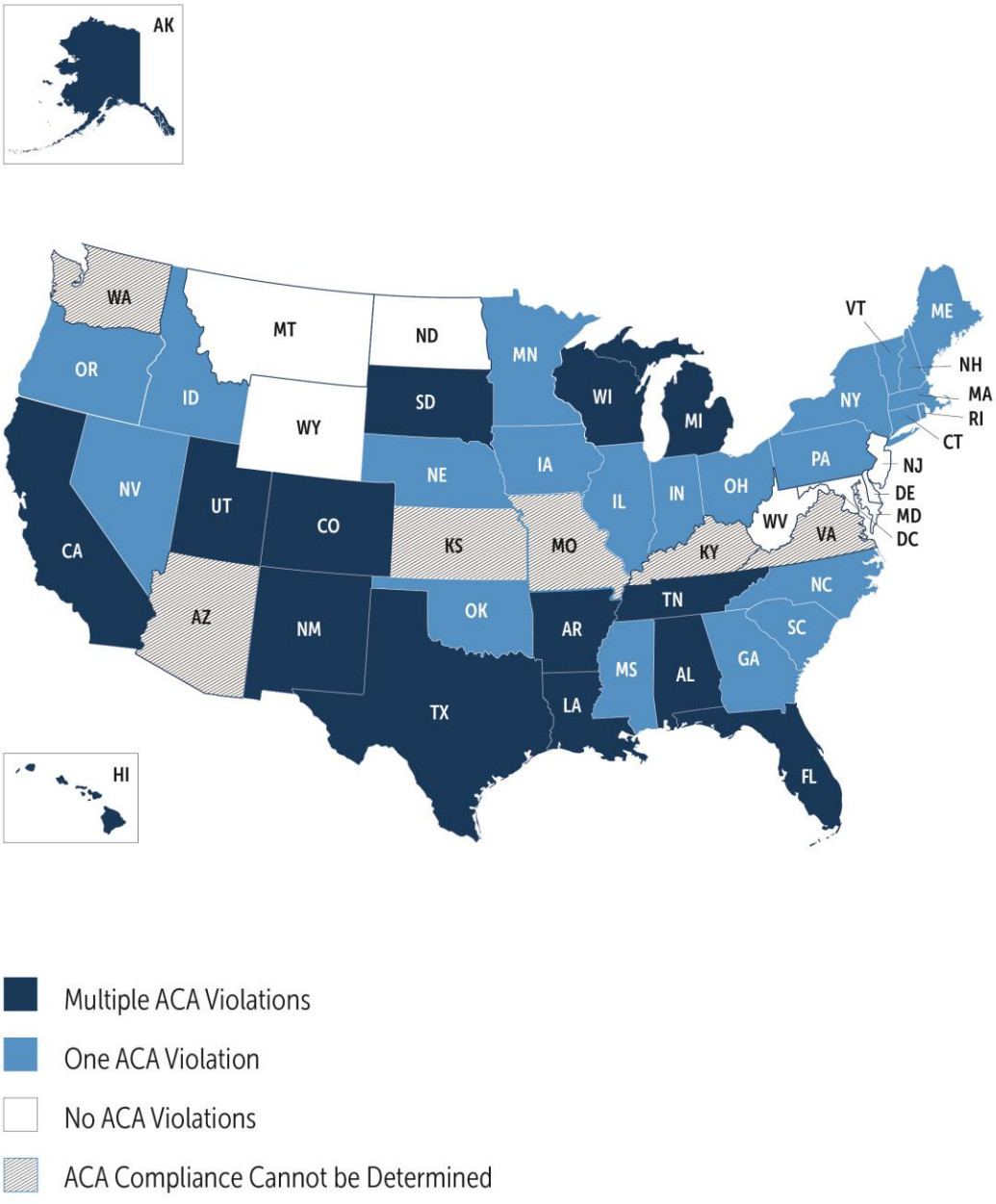
   Under the ACA's preventive services requirement, plans must cover screenings for tobacco use and at least two tobacco cessation attempts per year, each consisting of four tobacco cessation counseling sessions (at least 10 minutes each) and one 90-day treatment regimen of any FDA-approved tobacco cessation medication.[55]

   Plan formularies for the 2017 EHB-benchmark plans were not made available for review on CMS' website. But, the American Lung Association (ALA) tracks compliance with tobacco cessation coverage in the ACA Plans and compiled data about inclusion of the seven FDA-approved tobacco cessation medications in ACA Plan formularies.[56] Our Center utilized the formulary data collected by ALA to determine whether the 2017 EHB-benchmark plans cover all FDA-approved tobacco cessation medications, in accordance with the ACA's requirement.[†,57]

   - Twenty six of the 2017 EHB-benchmark plans are not in compliance with the ACA's requirement to cover tobacco cessation services.[‡]

[*] See *Appendix A* for detailed information about our findings.
[†] The Center was unable to match the 2017 EHB-benchmark plan to ALA's data for the following states: Arizona; Iowa; Kentucky; Louisiana; Missouri; Mississippi; New York; South Dakota; Utah; Virginia; and Washington.
[‡] Alabama; Arkansas; California; Colorado; Connecticut; Florida; Georgia; Hawaii; Idaho; Indiana; Louisiana; Maine; Massachusetts; Nebraska; New Hampshire; New Mexico; Nevada; Ohio; Oregon; Rhode Island; South Carolina; South Dakota; Tennessee; Utah; Vermont; and Wisconsin.

# ACA Violations



2. *Nearly half of the 2017 EHB-benchmark plans violate the ACA's requirement for coverage of prescription drugs to treat addiction*

The ACA requires coverage of at least one medication in the following classes for the Anti-Addiction/Substance Use Treatment Agents category: (1) Alcohol Deterrents/Anti-craving; (2) Opioid Dependence Treatments; (3) Opioid Reversal Agents; and (4) Smoking Cessation Agents.

According to the "Prescription Drug EHB-Benchmark Plan Benefits by Category and Class Summary" prepared by CMS for each state and posted on its website, 45 percent of the 2017 EHB-benchmark plans (23/51) are in violation of this requirement for coverage of SUD medications.

- The EHB-benchmark plans for California, Colorado, South Dakota and Wisconsin do not include coverage of at least one smoking cessation agent.
- Twenty EHB-benchmark plans do not include coverage of at least one opioid reversal agent.[*]

3. *Two of the 2017 EHB-benchmark plans violate the ACA by imposing a lifetime dollar limit on benefits*

The ACA prohibits the use of per beneficiary annual or lifetime dollar limits for EHB.[58] Yet, the 2017 EHB-benchmark plan for Texas violates this requirement by imposing a $5,000,000 maximum lifetime benefit per participant, and payments for SUD services apply towards the maximum lifetime benefit. Michigan's 2017 EHB-benchmark plan also places a limit on coverage for inpatient and outpatient SUD services up to a "minimum annual benefit of $3,671.00."[†]

4. *One 2017 EHB-benchmark plan violates the EHB requirement for coverage of SUD services*

Alaska's 2017 EHB-benchmark plan does not cover services and supplies relating to diagnosis and treatment of addiction. It only covers medically necessary detoxification services on the same basis as any other emergency medical condition. Detoxification is a treatment for withdrawal symptoms, not for the disease of addiction. Alaska's plan violates the EHB requirement because no SUD treatment services are covered.

5. *Plan documents for 11 of the EHB-benchmark plans lack sufficient detail to evaluate compliance with the ACA's requirements for coverage of SUD benefits*

- The EHB-benchmark plan documents for Arizona, Kansas, Pennsylvania and Washington do not address coverage for smoking cessation services.
- The EHB-benchmark plan documents for eight states do not address coverage for either alcohol use screening for adults or alcohol and drug use screening for adolescents.[‡]
- The EHB-benchmark plan documents for Hawaii, Idaho and Vermont do cover alcohol screening for adults but do not address coverage for alcohol and drug use screening for adolescents.

[*] Alabama; Alaska; Arkansas; Florida; Hawaii; Illinois; Iowa; Louisiana; Michigan; Minnesota; Mississippi; New Mexico; New York; North Carolina; Oklahoma; Pennsylvania; Tennessee; Texas; Utah; and Wisconsin.
[†] The plan documents for Michigan's 2017 EHB-benchmark plan do not define "minimum annual benefit."
[‡] Arizona; Connecticut; Kansas; Louisiana; Nebraska; Pennsylvania; South Carolina; and Washington.

## *Compliance with Parity Requirements*

Eighteen Percent of the 2017 EHB-Benchmark Plans Violate Parity Requirements; 31 Percent of the Plans Contain Possible Parity Violations

To satisfy the EHB requirement, SUD benefits must comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[59] Our review identified at least nine 2017 EHB-benchmark plans with facial parity violations and 16 plans with possible parity violations relating to coverage of intermediate services. Over 50 percent of the plan documents contain insufficient information to fully determine parity compliance. The plans selected to serve as the 2017 EHB-benchmark plans were offered in 2014 and therefore were not subject to MHPAEA.[*] As such, we do not assert that these findings are evidence that these EHB benchmark plans have violated the law. Further, EHB-benchmark plans simply define which SUD benefits ACA Plans must cover, they do not dictate what QTLs or NQTLs ACA Plans should apply. However, as templates for plans that will be offered in 2017 and must comply with MHPAEA, the 2017 EHB-benchmark plans should not contain provisions that would violate MHPAEA (see *Parity Violations* map on next page).[†]

1. *Six of the 2017 EHB-benchmark plans contain quantitative treatment limitations (QTLs) and/or cumulative QTLs that violate parity requirements*

MHPAEA prohibits the use of QTLs (e.g., limits on the 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.[60] Further, cumulative QTLs (e.g., lifetime limits) cannot accumulate separately from medical/surgical benefits when such benefits are in the same classification.[61]

- The EHB-benchmark plans for Alabama, Michigan, Mississippi, South Carolina and South Dakota violate parity requirements by imposing limits on the number of inpatient and/or outpatient visits for SUD services only.
- The EHB-benchmark plans for South Dakota and Texas violate parity requirements because they impose lifetime limits on SUD services only.

2. *Three EHB-benchmark plans contain cumulative financial requirements that violate parity*

Under MHPAEA, plans cannot require cumulative financial requirements (e.g., out-of-pocket maximums) for mental health and SUD benefits to accumulate separately from medical/surgical benefits when such benefits are in the same classification.[62]

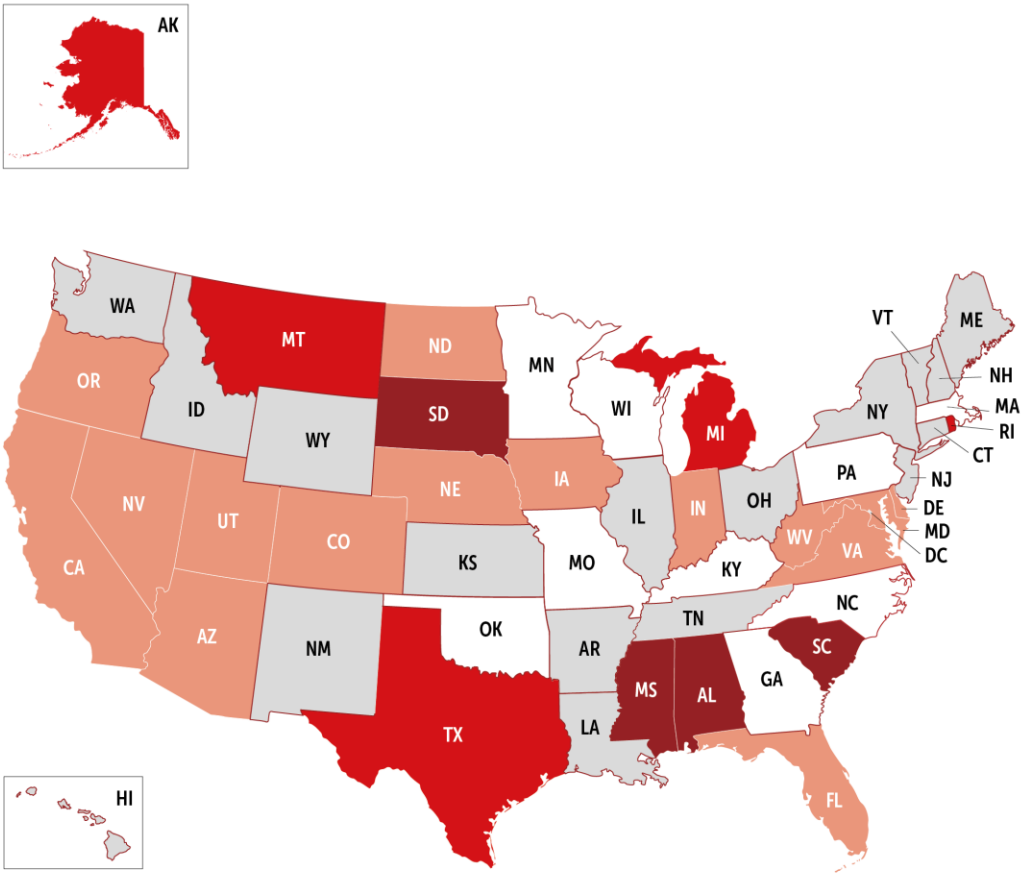
- The EHB-benchmark plans for Alabama, Mississippi and South Carolina violate parity requirements because coinsurance on SUD services does not apply toward the out-of-pocket maximum but coinsurance for medical/surgical services does apply.

3. *One-third of the 2017 EHB-benchmark plans contain possible parity violations related to coverage of intermediate SUD services*

There is ambiguity around the parity requirements for intermediate SUD services (e.g., residential, intensive outpatient and day/partial hospitalization treatment). As previously discussed, intermediate services may not fit squarely into MHPAEA's six benefit classifications.[63] MHPAEA does not require plans to cover intermediate services; rather, plans that cover intermediate SUD services must place

[*] This is due to the fact that the 2017 EHB-benchmark plans were selected from 2014 plans that were not subject to MHPAEA when they were created and logistical restrictions prevented the use of MHPAEA-compliant plans from serving as the 2017 EHB-benchmark plans.
[†] See *Appendix B* for detailed information about our findings.

# Parity Violations




Multiple Parity Violations

One Parity Violation

Possible Parity Violations

Parity Compliance Cannot be Determined

No Parity Violations

such services in the same category (e.g., outpatient/inpatient) as comparable intermediate medical services (e.g., skilled nursing facility and home health care).[64] For example, if a plan classifies treatment in a skilled nursing facility as an inpatient benefit, it must also classify residential treatment as an inpatient benefit; or if the plan classifies home health care as an outpatient benefit, it must also classify intensive outpatient and day/partial hospitalization as an outpatient benefit.[65] Then, within each classification, the MHPAEA rules regarding financial requirements (e.g., co-pays), QTLs (e.g., visit limits) and NQTLs (e.g., prior-authorization) apply.[66]

Due to the limited information provided in plan documents, it is not possible to determine how the benefits are classified and thus whether there is parity among SUD benefits and medical/surgical benefits in the same classification. Possible parity violations exist where plans impose different cost-sharing requirements or treatment limitations for intermediate SUD services as compared to intermediate medical services. According to our review:

- The 2017 EHB-benchmark plans for Arizona, California, Colorado, Maryland and Virginia contain possible parity violations because they impose higher cost-sharing obligations (co-pays) on intermediate SUD services as compared to intermediate medical services.
- Oregon's EHB-benchmark plan may violate parity by imposing a 45 day limit on residential treatment for SUDs while the comparable medical service, care in a skilled nursing facility, is subject to a 60 day limit.

The parity rules are also ambiguous with respect to the exclusion of intermediate SUD services (i.e., residential treatment) when plans cover comparable intermediate medical services (i.e., skilled nursing facilities). Some plans interpret the MHPAEA regulations strictly and believe the regulations allow such exclusions.[67] Many advocates believe that a broader reading of MHPAEA would not permit the scope of services to be covered in such an unequal manner. Advocates also argue that excluding intermediate SUD services while covering comparable intermediate medical services violates the ACA's non-discrimination requirement for EHB, as the exclusion is discriminatorily based on the patient's medical condition (addiction). 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.

- Thirteen EHB-benchmark plans contain possible parity violations by covering intermediate medical care in a skilled nursing facility, but excluding comparable intermediate SUD care in a residential treatment facility.[*]

4. *Two of the EHB-benchmark plans contain facial NQTL violations*

Under MHPAEA, plans must use processes, strategies, evidentiary standards, and other factors used in applying NQTLs to mental health or SUD benefits that are comparable to and applied no more stringently than those used for the medical/surgical benefits in the same classification.[68] Few of the plan documents contained sufficient information about NQTLs or how they are applied to allow a parity compliance assessment; however, two of the plans contained language that, on its face, would violate MHPAEA.

- Montana's EHB-benchmark plan contains a NQTL standard for SUD services that does not exist for medical/surgical services ("The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the [SUD].").

[*] Delaware; Florida; Indiana; Iowa; Mississippi; Nebraska; Nevada; North Dakota; Ohio; South Carolina; Texas; Utah; and West Virginia

- Rhode Island's EHB-benchmark plan contains an NQTL exception that is no longer permitted under MPHEA ("Preauthorization is applied to behavioral health services in the same way as medical benefits. The only exception is except where clinically appropriate standards of care may permit a difference.").*

5. *One plan violates parity by excluding non-emergency SUD services*

MHPAEA requires coverage of mental health and SUD benefits in every benefit classification where medical/surgical benefits are provided.[69] The only SUD service covered by Alaska's 2017 EHB-benchmark plan is emergency detoxification under the emergency room care benefits. This is a violation of parity as medical/surgical services are covered in other benefit classifications, such as inpatient and outpatient, but there are no SUD services covered in any benefit classifications other than emergency care.

6. *SUD benefits are not specified in one-third of the plan documents for the 2017 EHB-benchmark plans*

Thirty-three percent of the 2017 EHB-benchmark plans (17/51) do not provide comprehensive detailed information about the specific SUD services that are covered, making it impossible to determine whether there is parity among SUD services and medical services.

- Plan documents for 11 states' EHB-benchmark plans do not specify the SUD services that are covered.†
- Plan documents for six states' EHB-benchmark plans do not address coverage for intermediate SUD services (i.e., intensive outpatient, day/partial hospitalization, and residential services).‡

7. *Cost-sharing obligations are not specified in over one-third of the plan documents for the 2017 EHB-benchmark plans*

Parity applies to co-payments and other financial requirements.[70] Plan documents for more than one-third of the 2017 EHB-benchmark plans (19/51) do not contain specific information about cost-sharing obligations, making it impossible to determine whether there is parity in financial requirements among SUD services and medical/surgical services.§

## *Critical SUD Benefits and Harmful Treatment Limitations*

<u>None of the 2017 EHB-Benchmark Plans Provide Comprehensive Coverage for SUD by Covering the Full Array of Critical Benefits without Harmful Treatment Limitations</u>

In measuring the adequacy of benefits, we considered both the range of services and medications that are covered and the accessibility of those benefits. We found that a majority of the plans explicitly

* This exception appeared in the interim rule but was removed from the final rule. 78 Fed. Reg. 68,240, 68,245 (Nov. 13, 2013).
† Hawaii; Kansas; Mississippi; New Jersey; New Mexico; Ohio; Oregon; South Carolina; Utah; Washington; and Wyoming
‡ Alabama; Arkansas; Connecticut; Montana; New York; and West Virginia
§ Arkansas; Connecticut; District of Columbia; Florida; Idaho; Illinois; Iowa; Louisiana; Maine; Nebraska; Nevada; New Hampshire; New Jersey; New Mexico; New York; South Carolina; Tennessee; Vermont and Washington.

exclude critical SUD benefits and/or contain harmful treatment limitations. In the remainder of plans, the adequacy of SUD services covered cannot be determined because plan documents lack sufficient benefit information.

The two critical benefits that are most frequently excluded or not explicitly covered are residential treatment and methadone maintenance therapy. Residential treatment and methadone are evidence-based and cost-effective. The widespread exclusions and lack of coverage information in the EHB-benchmark plan documents are problematic given the demonstrated efficacy of these treatments (see *Inadequate SUD Coverage* map on next page).[*]

1. *Forty percent of the EHB-benchmark plans contain exclusions for critical SUD treatment and management services*

The EHB regulations do not define which SUD benefits must be covered in order to satisfy the EHB requirement; rather, states are allowed to define their own benefit package. While some variation in benefit packages is to be expected, several states have excluded benefits that are essential to effective treatment.

- Thirteen of the 2017 EHB-benchmark plans exclude residential treatment.[†]
- Seven EHB-benchmark plans exclude medication maintenance therapy (i.e., methadone).[‡]
- The only SUD service covered by Alaska's 2017 EHB-benchmark plan is emergency detoxification.

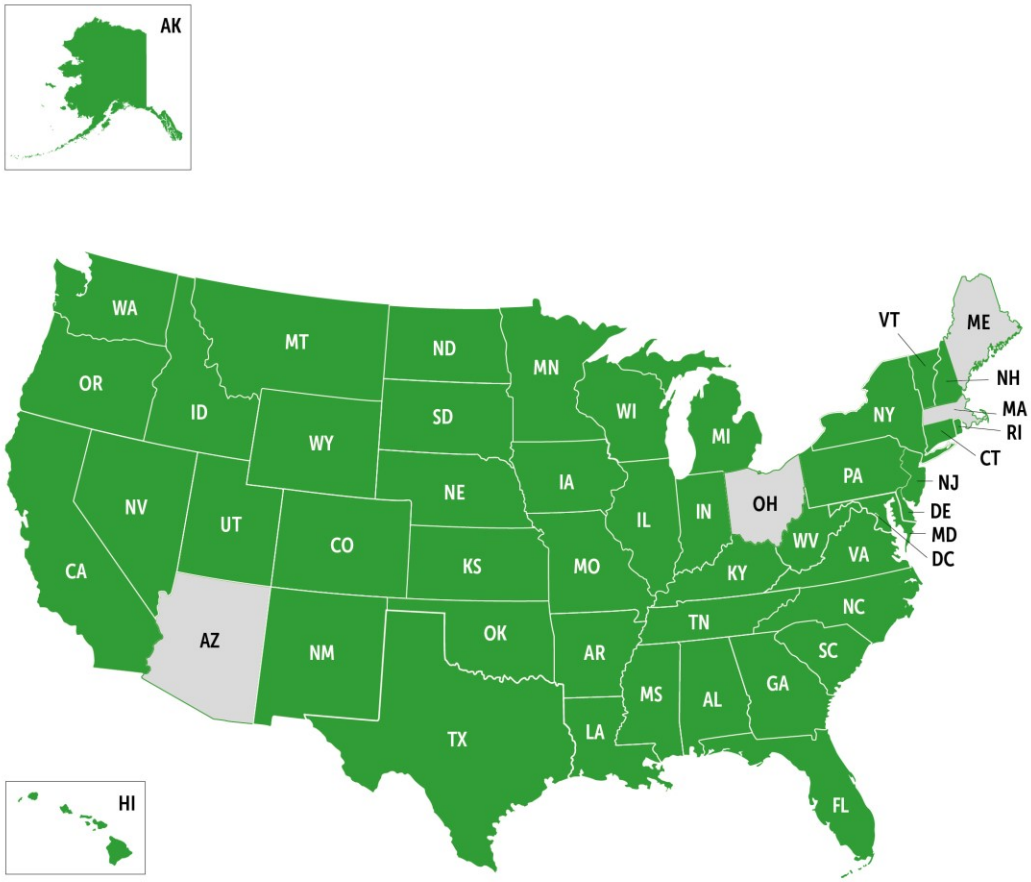
2. *A majority of the 2017 EHB-benchmark plans require prior authorization for SUD services*

Excessive prior authorization requirements can delay necessary clinical care and, because treatment retention is a challenge for people with addiction, delays can effectively inhibit access to appropriate clinical services.

- Thirty-three of the 2017 EHB-benchmark plans explicitly require prior authorization for a range of SUD services, including inpatient, outpatient, and intermediate SUD services (i.e., intensive outpatient, day/partial hospitalization and residential treatment).[§]
- Ten of the 2017 EHB-benchmark plans do not specify prior authorization requirements.[**]
- Six of the plans refer to the plan's website or customer services department for a list of services requiring prior authorization.[††]
- Rhode Island's 2017 EHB-benchmark plan recommends obtaining prior authorization for inpatient SUD treatment.

[*] See *Appendix C* for detailed information about our findings.
[†] Delaware; Florida; Indiana; Iowa; Mississippi; Nebraska; Nevada; North Dakota; South Carolina; South Dakota; Texas; Utah; and West Virginia
[‡] Alabama; Arkansas; Delaware; Kentucky; Rhode Island; Tennessee; and Wisconsin.
[§] Alabama; Arizona; Arkansas; Connecticut; Delaware; District of Columbia; Florida; Hawaii; Idaho; Illinois; Kansas; Kentucky; Louisiana; Maine; Maryland; Massachusetts; Michigan; Mississippi; Montana; Nebraska; Nevada; New Jersey; New Mexico; North Carolina; North Dakota; Oklahoma; Oregon; South Carolina; Tennessee; Texas; Utah; Vermont; and Wisconsin.
[**] Alaska; Colorado; Indiana; Minnesota; New Hampshire; New York; Ohio; Virginia; Washington; and Wyoming.
[††] Georgia; Iowa; Missouri; Pennsylvania; South Dakota; and West Virginia.

# SUD Benefit Adequacy




Inadequate SUD Coverage

Adequacy of SUD Coverage Cannot be Determined

3. *Nine of the 2017 EHB-benchmark plans have overly restrictive treatment limitations*

Blanket limitations on allowed visits or lengths of stay do not accord with best practices for treating cases of addiction that are chronic and relapsing. Length of treatment should be flexible and contingent on periodic evaluation of the patient's progress.

- Alabama, Michigan, Mississippi, South Carolina and South Dakota's EHB-benchmark plans place a limit on the number of days per contract/calendar year for inpatient and outpatient SUD services.
- South Dakota and Texas' EHB-benchmark plans impose lifetime limits on SUD services.
- Oregon's EHB-benchmark plan imposes a 45 day limit on residential treatment.
- Colorado's EHB-benchmark plan does not cover counseling services for a patient who is not responsive to therapeutic management.
- Vermont's EHB-benchmark plan only provides coverage for short-term residential treatment, which is not defined.

4. *All of the 2017 EHB-benchmark plans provide insufficient coverage for prescription drugs to treat opioid addiction*

All of the 2017 EHB-benchmark plans cover at least one Opioid Dependence Treatment (in compliance with the ACA's prescription drug requirement), but only eight plans cover all three medications in the USP Opioid Dependence Treatment class (buprenorphine, buprenorphine/naloxone and naltrexone).[*] Since methadone is not included in the USP Opioid Dependence Treatment class, the ACA does not technically require EHB-benchmark plans to cover methadone; however, as described above, methadone is a critical benefit for treatment of opioid use disorder. Based on the information available in the plan documents, our review found that:

- Seven of the 2017 EHB-benchmark plans explicitly exclude methadone.[†]
- The EHB-benchmark plans for the District of Columbia, Maryland and Minnesota explicitly cover methadone.
- None of the plans cover all of the FDA-approved drugs to treat opioid dependence (methadone, naltrexone/Vivitrol, buprenorphine, buprenorphine + naloxone).

5. *Sixty percent of the 2017 EHB-benchmark plans provide insufficient coverage for tobacco cessation*

In addition to the 26 states that provide inadequate coverage for tobacco cessation by failing to comply with ACA requirements, the EHB-benchmark plans for New Mexico and North Dakota place limits on smoking cessation services and products that, while compliant with the ACA's requirement for tobacco cessation coverage, are inappropriate. Like other types of SUDs, individuals with tobacco dependence are prone to relapse and may make multiple quit attempts before achieving long-term abstinence.[71] Placing annual limits on quit attempts or the use of evidence-based treatment can lead to prolonged tobacco use for individuals seeking to quit.[72]

[*] Arizona; Indiana; Maine; Massachusetts; Michigan; Ohio; South Carolina; and Virginia.
[†] Alabama, Arkansas, Delaware, Kentucky, Rhode Island, Tennessee and Wisconsin

6. *Two 2017 EHB-benchmark plans have Uniform Individual Accident and Sickness Policy Provision Laws (UPPL) provisions*

Mississippi and South Carolina's 2017 EHB-benchmark plans contain a UPPL provision, which allows insurance providers 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.

7. *Four 2017 EHB-benchmark plans have high cost sharing*

The 2017 EHB-benchmark plans for California, Colorado, Pennsylvania and Virginia require excessively high daily (e.g., $500 per day up to $2,500) or per admission ($750) copayments for inpatient and/or residential SUD services.

## *Description of SUD Benefits in Plan Documents*

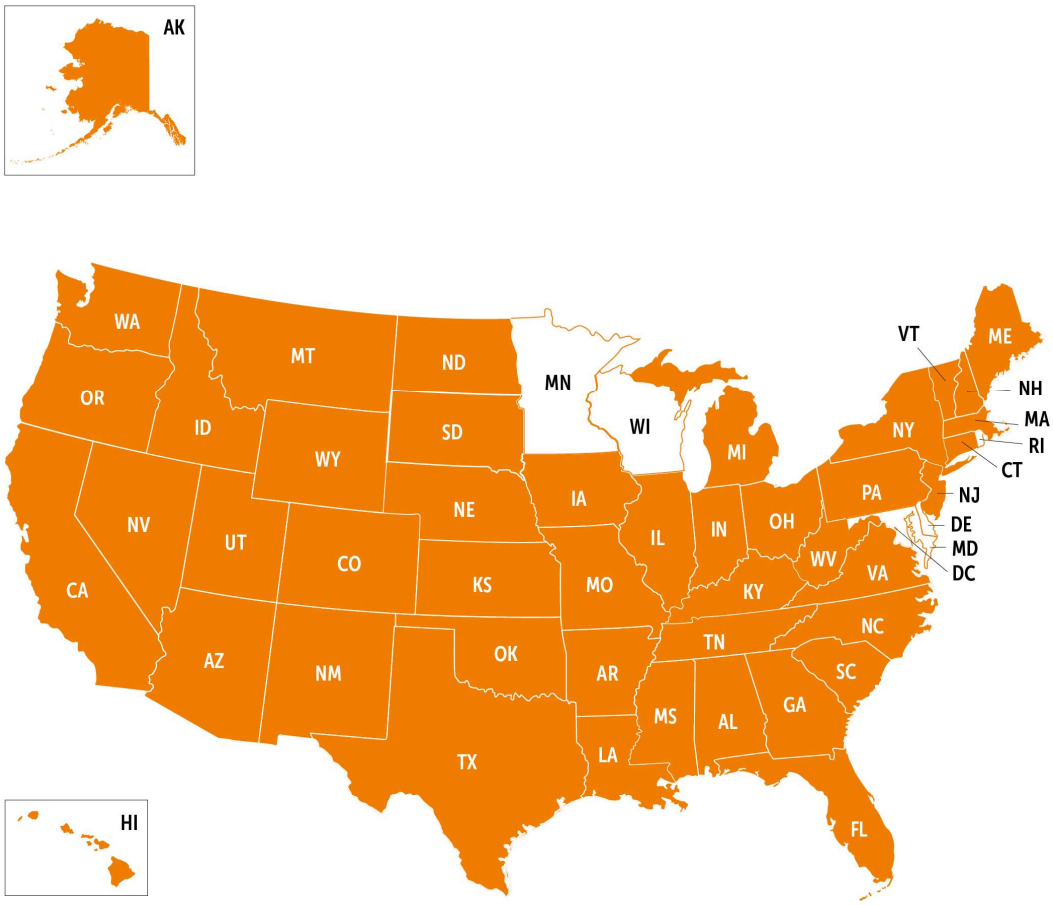
Plan Documents for 88 Percent of the 2017 EHB-Benchmark Plans Lack Sufficient Detail to Evaluate Compliance with the ACA and/or the Adequacy of SUD Benefits

In order to determine whether ACA Plans comply with EHB and parity requirements, the plan documents must provide detailed information about the specific SUD benefits that are covered and applicable cost-sharing requirements and treatment limitations. Detailed descriptions of the SUD benefits and limitations are also essential for consumers who are purchasing insurance and need to know whether a plan will pay for specific health services or medications.

Our review found that plan documents for 90 percent (46/51) of states' 2017 EHB-benchmark plans lacked sufficient detail to fully evaluate compliance with the ACA and/or the adequacy of SUD benefits.[*] Only Delaware, Maryland, Minnesota, Rhode Island and Wisconsin provided complete, detailed information regarding covered SUD benefits and applicable limitations (see *Description of SUD Benefits Plan Document is Insufficient* map on next page).

[*] Alabama; Alaska; Arizona; Arkansas; California; Colorado; Connecticut; Washington, D.C.; Florida; Georgia; Hawaii; Idaho; Illinois; Indiana; Iowa; Kansas; Kentucky; Louisiana; Maine; Massachusetts; Michigan; Mississippi; Missouri; Montana; Nebraska; Nevada; New Hampshire; New Jersey; New Mexico; New York; North Carolina; North Dakota; Ohio; Oklahoma; Oregon; Pennsylvania; South Carolina; South Dakota; Tennessee; Texas; Utah; Vermont; Virginia; Washington; West Virginia; and Wyoming

# Description of SUD Benefits in Plan Documents is Insufficient




Plan Documents Contain Insufficient Benefit Information

Plan Documents Contain Sufficient Benefit Information

# RECOMMENDATIONS

1. Cover all critical SUD benefits

A vast majority of the 2017 EHB-benchmark plans are not covering the full range of evidence-based SUD benefits that are critical in order to provide effective, quality treatment for addiction. Excluding critical SUD treatments, in most cases, violates the ACA's requirements for coverage of SUD benefits and parity. Further, it harms patients and escalates costs. One glaring example of inadequate coverage of SUD services is Alaska's 2017 EHB-benchmark plan, which only covers medically necessary detoxification services and does not cover any services relating to the treatment of addiction.

The 2017 EHB-benchmark plans with SUD coverage inadequacies should be updated to ensure that ACA plans in every state are required to cover the full range of critical SUD benefits.

2. Cover all FDA-approved SUD medications

To provide optimal care, 2017 EHB-benchmark plans should cover all FDA-approved medications for treatment of addiction.

Further, the EHB prescription drug requirement should be changed to include coverage of methadone. Currently, methadone is not included in the USP class for Opioid Dependence Treatment because its dispensing requirements are incompatible with certain Medicare requirements. There is no medical justification for excluding coverage of methadone for the treatment of opioid addiction from ACA Plans. Methadone has been used to treat opioid addiction for the past 50 years and its efficacy is well demonstrated. Further, patients on methadone maintenance therapy cannot be easily switched to another type of medication without risk of harm. All necessary statutory or regulatory changes should be enacted to require coverage of methadone by the ACA plans.

3. Remove harmful/excessive treatment limitations

Tailoring treatment to the specific needs of the patient by matching the patient to the appropriate level of care and flexibility in length of treatment are crucial components when treating patients with chronic SUDs. Blanket limitations on allowed visits and levels of care serve to impede access to critical care and often violate parity requirements. The ACA Plans should make treatment limitations as unrestrictive as possible to ensure patients can access care when they need it.

4. Prohibit the use of Uniform Individual Accident and Sickness Policy Provision Laws (UPPL)

UPPL provisions should be eliminated in plan documents for the two EHB-benchmark plans in which they currently appear and any use of UPPL provisions should be prohibited in all ACA Plans.

5. Eliminate exceedingly high cost-sharing

Remove high daily or per admission co-payments for SUD services in ACA Plans and find ways to ensure that cost-sharing obligations do not deter patients from seeking necessary care.

6. Review and revise 2017 EHB-benchmark plans

The states and the federal government should review all 2017 EHB-benchmark plans for ACA and parity compliance and benefit adequacy and, when deficiencies are found, issuers of non-compliant plans should be required to revise their plan documents to ensure transparency, compliance with the law, and access to the full range of critical SUD benefits.

7. Ensure compliance in the EHB-benchmark plans

States should ensure that their EHB-benchmark plans, and all ACA Plans sold in their state, are compliant with all legal requirements and offer a comprehensive array of SUD benefits, particularly in the SUD, preventive services and prescription drug EHB categories. Where a state has declined to enforce the ACA, the federal government must assume this obligation.

8. Issue additional parity guidance on prior authorization requirements

A majority of the 2017 EHB-benchmark plans require prior authorization for a range of SUD services. Even in cases where such requirements are technically in parity with prior authorization requirements for comparable medical services, excessive prior authorization requirements are not clinically appropriate for treatment of SUDs, as they can delay necessary clinical care and inhibit access to appropriate clinical services. The Department of Health and Human Services (HHS) and the other agencies responsible for implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) should confirm whether prior authorization requirements for SUD benefits violate parity when they are not clinically appropriate or, if no parity violation is found, ask states to consider removing these requirements.

9. Issue additional parity guidance on requirements for coverage of intermediate services

Additional guidance is needed with respect to parity requirements for intermediate services because the regulations are ambiguous. The current requirement for plans that cover intermediate SUD services to assign such benefits to the same benefit classification as comparable intermediate medical services is inadequate for ensuring equal coverage of intermediate services. Several 2017 EHB-benchmark plans cover intermediate medical services (i.e., skilled nursing facility, home health care) but exclude or omit information about coverage of intermediate SUD services (i.e., residential treatment, intensive outpatient, day/partial hospitalization programs). Allowing plans to cover intermediate medical services but exclude comparable intermediate SUD services undermines the purpose of MHPAEA as patients with SUDs have unequal access to the full continuum of services provided for patients with medical conditions. Further, an exclusion of residential treatment for SUDs is discriminatorily based on the patient's medical condition (addiction) and violates the ACA's non-discrimination clause. Covering intermediate medical services but excluding comparable intermediate SUD services should not be permissible under MHPAEA or the ACA.

10. Issue additional parity guidance on copayment requirements

Several states require the specialist provider copayment/coinsurance for outpatient SUD services instead of the copayment/coinsurance required for primary care providers. In addition, some states require different cost-sharing for intermediate services. Evaluating parity among financial requirements is complicated and requires determining the predominant financial requirement applied to substantially all benefits. This analysis requires information that is not readily accessible to patients and advocates, such as benefit classifications, the type of financial requirements applied to all benefits in the classification, and the expected annual dollar amount of all payments in the benefit classification. Patients and advocates need further guidance on how to identify possible parity violations in cost-sharing and how to raise such issues to the appropriate enforcement authority. The federal agencies responsible for MHPAEA

implementation should provide guidance to patients and advocates to help identify and report possible parity violations with respect to cost-sharing obligations.

11. Require plans to revise plan documents with insufficient benefit information

In order to define EHB and serve as a reference plan for the ACA Plans in the state, the plan documents for EHB-benchmark plans must be thorough and comprehensive and provide easily understood information about the scope of benefits and cost-sharing obligations. Such detail is also required to make public review of proposed EHB-benchmark plans meaningful and to provide consumers with sufficient information to make informed decisions when choosing their health plan. Despite the importance of thorough benefit information, 88 percent of the plan documents for the 2017 EHB-benchmark plans lack sufficient information regarding SUD benefits and/or cost-sharing. The 2017 EHB-benchmark plans should be revised to ensure that benefit information is detailed and comprehensive and includes information about the types and levels of SUD services and medications that are covered as well as applicable cost-sharing.

## CONCLUSION

While the ACA expanded insurance coverage to millions of Americans and designated SUD services as an EHB, this has not sufficiently increased access to evidence-based SUD treatment. All of the 2017 EHB-benchmark plans are non-compliant with the ACA's requirements and/or provide inadequate SUD benefits. In order to fulfill the ACA's intent of dramatically expanding access to SUD services, the EHB-benchmark plans should be revised to ensure comprehensive coverage of evidence-based SUD services and medications without harmful treatment limitations and compliance with the ACA's requirements for the coverage of SUD benefits, including parity. This will not only fulfill the spirit of the law and have a tremendous positive impact on patients seeking medically-necessary and life-saving care, it can also be expected to decrease costs for the health plans in the long-term.

# Appendix A

| State | # of violations | ACA Violations | | | | |
|---|---|---|---|---|---|---|
| | | SUD | Tobacco Cessation (*data from plan documents and ALA Data*) | Alcohol Use Screening (and drug use screening for adolescents) | Prescription Drug (*data from CMS benchmark summaries*) | Lifetime/Annual Limits |
| Alabama (AL) | 2 | | • The plan documents state services related to nicotine addiction, such as smoking cessation treatment are excluded; but, "expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist from an in-network pharmacy" are covered. While Alabama's 2017 EHB-benchmark plan provides coverage for tobacco cessation medications, at least four tobacco cessation counseling sessions per tobacco cessation attempt must also be covered to comply with the requirement. | | • No coverage for opioid reversal drug. | |
| Alaska (AK) | 2 | • Treatment of chemical dependency is not covered under Hospital Inpatient Care Treatment or Emergency Room Care benefits, but the medically necessary detoxification services are covered on the same basis as any other emergency medical condition.<br><br>• Services and supplies relating to diagnosis and treatment of chemical dependency and non-dependent alcohol/drug use/abuse are not covered. | | | • No coverage for opioid reversal drugs. | |
| Arizona (AZ) | Cannot be determined | | • *Cannot match ALA data to EHB Plan.*<br><br>• Plan documents are silent on coverage for tobacco cessation services. | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | | |
| Arkansas (AR) | 2 | | • The plan documents state that the treatment of nicotine addiction is excluded and that smoking cessation products not on the plan's formulary are not covered. While Arkansas's 2017 EHB-benchmark plan provides coverage for tobacco cessation medications, at least four tobacco cessation counseling sessions per tobacco cessation attempt must also be covered to comply with the requirement. | | • No coverage for opioid reversal drug. | |
| California (CA) | 2 | | • According to ALA's formulary data, California's 2017 EHB-benchmark plan does not include three FDA-approved tobacco cessation medications on its formulary: nicotine nasal spray, nicotine inhaler, and Varenicline. | | • No coverage for smoking cessation agents. | |
| Colorado (CO) | 2 | | • According to ALA's formulary data, Colorado's 2017 EHB-benchmark plan does not include six FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, nicotine lozenge, nicotine nasal spray, nicotine inhaler, and Varenicline. | | • No coverage for smoking cessation agents. | |
| Connecticut (CT) | 1 | | • According to ALA's formulary data, Connecticut's 2017 EHB-benchmark plan does not include five FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, nicotine lozenge, nicotine nasal spray and nicotine inhaler. | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | | |
| Delaware (DE) | 0 | | | | | |
| District of Columbia (DC) | 0 | | | | | |
| Florida (FL) | 2 | | • The plan documents state, "smoking cessation programs including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.)" are excluded. In addition, according to ALA's formulary data, Florida's 2017 EHB-benchmark plan does not include one FDA-approved tobacco cessation medication on its formulary: nicotine lozenge. | | • No coverage for opioid reversal agent. | |
| Georgia (GA) | 1 | | • The plan documents state, "treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, or electronic media" is not covered. | | | |
| Hawaii (HI) | 2 | | • According to ALA's formulary data, Hawaii's 2017 EHB-benchmark plan does not include one FDA-approved tobacco cessation medications on its formulary: nicotine lozenge. | • Plan documents are silent regarding coverage of HRSA supported preventive services and screenings for children and adolescents. | • No coverage for opioid reversal drug. | |

| State | # of violations | ACA Violations | | | | |
|---|---|---|---|---|---|---|
| | | SUD | Tobacco Cessation (*data from plan documents and ALA Data*) | Alcohol Use Screening (and drug use screening for adolescents) | Prescription Drug (*data from CMS benchmark summaries*) | Lifetime/Annual Limits |
| Idaho (ID) | 1 | | • According to ALA's formulary data, Idaho's 2017 EHB-benchmark plan does not include three FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, and nicotine lozenge. Further, plan documents state a limit of a 90-day supply per benefit period for Chantix Smoking Cessation Prescription Drugs. A 90 day supply is required per tobacco cessation attempt and at least two attempts must be covered each year. Finally, the plan documents covered prescription drugs for smoking cessation to Chantix and/or Bupropion SR (Zyban). Plans must cover all FDA-approved tobacco cessation medications. | • Plan documents are silent regarding coverage of drug use screening for adolescents. | | |
| Illinois (IL) | 1 | | | | • No coverage for opioid reversal drug. | |
| Indiana (IN) | 1 | | • According to ALA's formulary data, Indiana's 2017 EHB-benchmark plan does not include four FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, nicotine lozenge, and nicotine nasal spray. | | | |
| Iowa (IA) | 1 | | • *Cannot match ALA data to EHB Plan.* | | • No coverage for opioid reversal drug. | |
| Kansas (KS) | Cannot be determined | | • Plan documents are silent on coverage for tobacco cessation services. | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | | |
| Kentucky (KY) | Cannot be determined | | • *Cannot match ALA Data to EHB Plan.* | | | |
| Louisiana (LA) | 2 | | • The plan documents state smoking cessation programs and products, except Zyban, are excluded. Plans must cover all FDA approved tobacco cessation medications.<br><br>• *Cannot match ALA Data to EHB Plan.* | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | • No coverage for opioid reversal drug. | |
| Maine (ME) | 1 | | • According to ALA's formulary data, Maine's 2017 EHB-benchmark plan does not include four FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, nicotine lozenge and nicotine inhaler. | | | |
| Maryland (MD) | 0 | | | | | |
| Massachusetts (MA) | 1 | | • Plan documents state coverage of smoking cessation aids is limited to one 90-day supply per member per calendar year. A 90 day supply is required per tobacco cessation attempt and at least two attempts must be covered each year. | | | |
| Michigan (MI) | 2 | | | | • No coverage for opioid reversal drug. | • Annual limit violation: Inpatient and outpatient services for substance abuse care are covered up to minimum annual benefit of $3,671 (language appears in certificate rider and term is not defined). |
| Minnesota (MN) | 1 | | | | • No coverage for opioid reversal drug. | |
| Mississippi (MS) | 1 | | • *Cannot match ALA Data to EHB Plan.* | | • No coverage for opioid reversal drug. | |
| Missouri (MO) | Cannot be determined | | • *Cannot match ALA Data to EHB Plan.* | | | |
| Montana (MT) | 0 | | | | | |
| Nebraska (NE) | 1 | | • The plan documents state, "services, supplies, equipment, procedures, drugs or programs for treatment of nicotine addiction" are excluded. | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | | |
| Nevada (NV) | 1 | | • According to ALA's formulary data, Nevada's 2017 EHB-benchmark plan does not include three FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, and nicotine lozenge. | | | |
| New Hampshire (NH) | 1 | | • According to ALA's formulary data, New Hampshire's 2017 EHB-benchmark plan does not include three FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, and nicotine lozenge. | | | |
| New Jersey (NJ) | 0 | | | | | |

| State | # of violations | ACA Violations | | | | |
|---|---|---|---|---|---|---|
| | | SUD | Tobacco Cessation (*data from plan documents and ALA Data*) | Alcohol Use Screening (and drug use screening for adolescents) | Prescription Drug (*data from CMS benchmark summaries*) | Lifetime/Annual Limits |
| New Mexico (NM) | 2 | | • According to ALA's formulary data, New Mexico's 2017 EHB-benchmark plan does not include three FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, and nicotine lozenge. | | • No coverage for opioid reversal drug. | |
| New York (NY) | 1 | | • *Cannot match ALA Data to EHB Plan.*<br><br>• Note, while plan documents contain template language that allows the plan to choose whether or not to cover smoking cessation services, services with an "A" or "B" rating from the USPSTF are covered. | | • No coverage for opioid reversal drug. | |
| North Carolina (NC) | 1 | | | | • No coverage for opioid reversal drug. | |
| North Dakota (ND) | 0 | | | | | |
| Ohio (OH) | 1 | | • The plan documents state that there is no coverage for "drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products." In addition, according to ALA's formulary data, Ohio's 2017 EHB-benchmark plan does not include four FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, nicotine lozenge, and nicotine nasal spray. | | | |
| Oklahoma (OK) | 1 | | | | • No coverage for opioid reversal drug. | |
| Oregon (OR) | 1 | | • Plan documents state that there is a maximum lifetime benefit of 2 quit attempts for tobacco cessation but the ACA requires coverage for 2 quit attempts per year. | | | |
| Pennsylvania (PA) | 1 | | • Plan documents are silent on coverage for tobacco cessation services. | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | • No coverage for opioid reversal drug. | |
| Rhode Island (RI) | 1 | | • According to ALA's formulary data, Rhode Island's 2017 EHB-benchmark plan does not include six FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, nicotine lozenge, nicotine nasal spray, nicotine inhaler, and Varenicline. | | | |
| South Carolina (SC) | 1 | | • The plan documents state, "prescription drugs used for . . . smoking cessation" are not covered. | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | | |
| South Dakota (SD) | 2 | | • The plan documents state, "tobacco dependency drugs are not covered."<br><br>• *Cannot match ALA Data to EHB Plan.* | | • No coverage for smoking cessation agents. | |
| Tennessee (TN) | 2 | | •According to ALA's formulary data, Tennessee's 2017 EHB-benchmark plan does not include three FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine lozenge, and nicotine nasal spray. In addition, plan documents do not describe coverage for smoking cessation programs/products outside screening and counseling in primary care setting. | | • No coverage for opioid reversal agent. | |
| Texas (TX) | 2 | | | | • No coverage for opioid reversal agent. | • All payments for SUD services apply toward a "Maximum Lifetime Benefit" of $5,000,000 per participant. |
| Utah (UT) | 2 | | • Plan documents state that tobacco abuse is excluded from mental health benefit but tobacco use cessation interventions are covered under pharmacy plan. It is not clear whether such coverage includes all FDA–approved tobacco cessation medications and at least four counseling sessions per tobacco cessation attempt, as required.<br><br>• *Cannot match ALA Data to EHB Plan.* | | • No coverage for opioid reversal agent. | |

| State | # of violations | ACA Violations | | | | |
|---|---|---|---|---|---|---|
| | | SUD | Tobacco Cessation (*data from plan documents and ALA Data*) | Alcohol Use Screening (and drug use screening for adolescents) | Prescription Drug (*data from CMS benchmark summaries*) | Lifetime/Annual Limits |
| Vermont (VT) | 1 | | • According to ALA's formulary data, Vermont's 2017 EHB-benchmark plan does not include five FDA-approved tobacco cessation medications on its formulary: nicotine gum, nicotine patch, nicotine lozenge, nicotine nasal spray, and nicotine inhaler. Plan documents also state that tobacco cessation drugs are limited to a three month supply per plan year. A 90 day supply is required per tobacco cessation attempt and at least two attempts must be covered each year. | • Plan documents are silent regarding coverage of HRSA supported preventive services and screenings for children and adolescents. | | |
| Virginia (VA) | Cannot be determined | | • *Cannot match ALA Data to EHB Plan.* | | | |
| Washington (WA) | Cannot be determined | | • *Cannot match ALA Data to EHB Plan.*<br><br>• Plan documents are silent on coverage for tobacco cessation services. | • Plan documents are silent on coverage for alcohol use screening for adults and adolescents and drug use screening for adolescents. | | |
| West Virginia (WV) | 0 | | | | | |
| Wisconsin (WI) | 2 | | • The plan documents state, "Prescription Drug Products for smoking cessation" and "stand-alone multi-disciplinary smoking cessation programs" are excluded. | | • No coverage for opioid reversal agent or smoking cessation agent. | |
| Wyoming (WY) | 0 | | | | | |

# Appendix B

| State | # of violations | Parity Violations | | | | | Notes |
|---|---|---|---|---|---|---|---|
| | | Treatment Limitations (QTLs) *(including cumulative QTLs)* | Cumulative Financial Requirements | Intermediate Services (Possible Parity Violation) | Other | Parity Compliance Cannot be Determined | |
| Alabama (AL) | 2 violations | • Limit on inpatient services of 30 days per calendar year (Expanded Psychiatric Services (EPS) provider) or 30 days per 12 consecutive months (non-EPS provider) and limit on outpatient services to 30 days per calendar year (EPS provider) and 20 visits per calendar year (non-EPS provider); no calendar year limit for inpatient medical/surgical services or physician outpatient visits. | • Facility and physician expenses for mental health and substance abuse do not count toward out-of-pocket maximum. | | | • Plan documentsare silent on intermediate treatment (intensive outpatient/partial hospitalization).<br><br>• Unclear whether residential treatment is always excluded or only when care is coordinated by a non EPS provider. | |
| Alaska (AK) | 1 violation | | | | • SUD treatment is limited to emergency treatment. | | |
| Arizona (AZ) | Possible violations | | | • $150 copayment for residential substance abuse services, but skilled nursing facility services are not subject to cost-sharing (*possible violation*). | | | |
| Arkansas (AR) | Cannot be determined | | | | | • Coverage for long term residential treatment for mental health is excluded; coverage for SUD residential treatment is not addressed.<br><br>• Schedule of benefits not provided. | • SUD outpatient treatment subject to specialist provider copay. |
| California (CA) | Possible violation | | | • $100 copayment per admission to a nonmedical transitional recovery setting but skilled nursing facility admissions are not subject to cost-sharing (*possible violation*). | | | |
| Colorado (CO) | Possible violations | | | • $750 copayment per admission for residential treatment while skilled nursing facility services are not subject to cost-sharing (*possible violation*).<br><br>• $30 copayment per partial hospitalization day while home health care services are not subject to cost-sharing (*possible violation*). | | | |

| State | # of violations | Parity Violations | | | | | Notes |
|---|---|---|---|---|---|---|---|
| | | Treatment Limitations (QTLs) *(including cumulative QTLs)* | Cumulative Financial Requirements | Intermediate Services (Possible Parity Violation) | Other | Parity Compliance Cannot be Determined | |
| Connecticut (CT) | Cannot be determined | | | | | • Unclear whether residential treatment is covered for SUD - appears to only be covered for individuals with "emotional disturbances."<br><br>• Benefit Summary not provided (cost-sharing obligations cannot be determined). | |
| Delaware (DE) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | | • specialist provider copayment for outpatient SUD ($60 copay for SUD outpatient services); $40 copay for primary care provider and $60 copay for specialist provider. |
| District of Columbia (DC) | Cannot be determined | | | | | • No cost sharing information. | |
| Florida (FL) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • Specific cost-sharing information not provided in plan documents. | |
| Georgia (GA) | None | | | | | | |
| Hawaii (HI) | Cannot be determined | | | | | • Not clear what specific levels of care are covered. | • Unclear whether residential treatment is covered (plan documents only state pre-certification is required for out-of-state facilities). |
| Idaho (ID) | Cannot be determined | | | | | • No cost sharing information. | |
| Illinois (IL) | Cannot be determined | | | | | • Cost sharing requirements not provided. | |
| Indiana (IN) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | | |
| Iowa (IA) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • Cost-sharing Information is provided for outpatient visits but not for inpatient or intermediate treatment. | |
| Kansas (KS) | Cannot be determined | | | | | • Not clear what specific levels of care are covered. | |
| Kentucky (KY) | None | | | | | | |
| Louisiana (LA) | Cannot be determined | | | | | • No cost sharing information. | |

| State | # of violations | Parity Violations | | | | | Notes |
|---|---|---|---|---|---|---|---|
| | | Treatment Limitations (QTLs) *(including cumulative QTLs)* | Cumulative Financial Requirements | Intermediate Services (Possible Parity Violation) | Other | Parity Compliance Cannot be Determined | |
| Maine (ME) | Cannot be determined | | | | | • No cost sharing information. | |
| Maryland (MD) | Possible violations | | | • $250 copayment per admission to a residential facility and $20–$30 copayments for professional services, while a skilled nursing facility is subject to a $30 copayment per admission (*possible violation*).<br><br>• Partial hospitalization services are subject to a $30 copayment per visit and $30 copayment per provider per date of service, while home health care services are not subject to cost-sharing. (*possible violation*). | | | |
| Massachusetts (MA) | None | | | | | | |
| Michigan (MI) | 1 violation | • Limit of 10 days per year for inpatient SUD services and 30 visits per year for outpatient SUD services; no similar limit on medical/surgical benefits. *Note this information appears on the Michigan 2017 EHB Benchmark Plan Summary but does not appear in the Plan Documents*. | | | | | |
| Minnesota (MN) | None | | | | | | |
| Mississippi (MS) | 2 violations | • Annual limit of 7 days per year for inpatient care and 20 days per year for outpatient care; no similar limit on medical/surgical benefits. | • Coinsurance for Covered Services incurred for treatment of alcohol abuse and drug abuse cannot be used to satisfy the Medical out-of-pocket amount and once the Medical out-of-pocket amount has been satisfied, services incurred for treatment of alcohol and drug abuse will not be paid at 100% of Allowable Charges. | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • Not clear what specific levels of care are covered. | |
| Missouri (MO) | None | | | | | | |

| State | # of violations | Parity Violations | | | | | Notes |
|---|---|---|---|---|---|---|---|
| | | Treatment Limitations (QTLs) *(including cumulative QTLs)* | Cumulative Financial Requirements | Intermediate Services (Possible Parity Violation) | Other | Parity Compliance Cannot be Determined | |
| Montana (MT) | 1 violation | | | | • NQTL violation: plan documents state, "the treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Chemical Dependency" but no similar condition exists for medical/surgical (same process needs to apply). | • Not clear what intermediate services are covered. | • Copays are 20% for SUD services (in-network) but are $30 for primary care provider visits and $50 for specialist provider visit. |
| Nebraska (NE) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • No specific information about cost-sharing. | |
| Nevada (NV) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • No specific cost sharing information. | |
| New Hampshire (NH) | Cannot be determined | | | | | • No specific information about cost-sharing. | • Text in plan documents suggest there may be visit limitations ("if you exhaust any annual limits showing on the Schedule of Benefits for mental illness") but the Schedule of Benefits included in the plan documents is blank. |
| New Jersey (NJ) | Cannot be determined | | | | | • Not clear what levels of SUD services are covered.<br><br>• No information on cost-sharing for SUD services. | |
| New Mexico (NM) | Cannot be determined | | | | | • Acute detoxification as an inpatient hospital benefit and residential treatment are the only services mentioned - not clear what other SUD services are covered.<br><br>• No information on cost-sharing obligations.<br><br>• Plan documents reference maximum episodes of treatment" for Alcoholism and/or Substance Abuse services but "maximum episodes of treatment" is not defined or quantified. | |

| State | # of violations | Parity Violations | | | | | Notes |
|---|---|---|---|---|---|---|---|
| | | Treatment Limitations (QTLs) *(including cumulative QTLs)* | Cumulative Financial Requirements | Intermediate Services (Possible Parity Violation) | Other | Parity Compliance Cannot be Determined | |
| New York (NY) | Cannot be determined | | | | | • No mention of intermediate level services. Plan documents state inpatient rehabilitation services are covered but do not explicitly address residential services.<br><br>• No information on cost-sharing obligations. | |
| North Carolina (NC) | None | | | | | | |
| North Dakota (ND) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential treatment SUD services (residential treatment excluded over age 21) (*possible violation*). | | | |
| Ohio (OH) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • Not clear what specific SUD treatment benefits are offered. | |
| Oklahoma (OK) | None | | | | | | |
| Oregon (OR) | Possible violation | | | • 45 day limit on residential treatment; Skilled nursing days limited to 60 days per year (*possible violation*). | | • Plan documents do not clearly address the types of SUD services that are covered. | |
| Pennsylvania (PA) | None | | | | | | • Parity with cost-sharing for specialist provider but not primary care provider (specialist provider copay is $60 copay per service/occurrence; $30 copay per primary care provider visit). |
| Rhode Island (RI) | 1 violation | | | | • NQTL violation: The plan documents for Rhode Island state: "Preauthorization is applied to behavioral health services in the same way as medical benefits. The only exception is except where clinically appropriate standards of care may permit a difference." This exception appeared in the MHPAEA Interim Rule but was removed from the Final Rule. | | |

| State | # of violations | Parity Violations | | | | | Notes |
|---|---|---|---|---|---|---|---|
| | | Treatment Limitations (QTLs) *(including cumulative QTLs)* | Cumulative Financial Requirements | Intermediate Services (Possible Parity Violation) | Other | Parity Compliance Cannot be Determined | |
| South Carolina (SC) | 2 violations | • Imposes a limit of seven days per benefit period for inpatient SUD services and 25 visits per benefit period for outpatient/office visits for mental health services/substance abuse care (combined); no such limit of medical/surgical services. *Note this information appears on the South Carolina 2017 EHB Benchmark Plan Summary but does not appear in the Plan Documents.* | • Coinsurance on mental health and SUD services do not apply toward out of pocket maximum. | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • Not clear what specific SUD treatment benefits are offered.<br><br>• No information about cost sharing. | |
| South Dakota (SD) | 2 violations | • Limit of 30 days per six-month period for inpatient treatment for alcoholism.<br><br>• Inpatient treatment for all other substance abuse services limited to 30 days per benefit year; no such limit for medical/surgical services.<br><br>• Limit of 90 days per lifetime for inpatient treatment for alcoholism (*cumulative QTL*). | | | | | • Charge specialist provider copayment. |
| Tennessee (TN) | Cannot be determined | | | | | • No information about cost-sharing. | |
| Texas (TX) | 1 violation | • Maximum lifetime benefit of three separate series of SUD inpatient treatments (*cumulative QTL*). | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | | |
| Utah (UT) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • SUD services not specified (only Mental Health services). | |
| Vermont (VT) | Cannot be determined | | | | | • No specific cost sharing information. | |
| Virginia (VA) | Possible violation | | | • $250 copayment for partial hospitalization and intensive outpatient services while home health care services are subject to a $10 copayment per visit (*possible violation*). | | | |

| State | # of violations | Parity Violations | | | | | Notes |
|---|---|---|---|---|---|---|---|
| | | Treatment Limitations (QTLs) *(including cumulative QTLs)* | Cumulative Financial Requirements | Intermediate Services (Possible Parity Violation) | Other | Parity Compliance Cannot be Determined | |
| Washington (WA) | Cannot be determined | | | | | • No specific benefit information provided.<br><br>• No cost sharing information. | • Plan documents do not contain any benefit information. |
| West Virginia (WV) | Possible violation | | | • Skilled nursing facilities are covered; should have parity with residential SUD services (*possible violation*). | | • Only mentions residential; Intermediate level services (intensive outpatient, partial hospitalization) not addressed. | • Parity with cost sharing for outpatient SUD services and the specialist provider copay ($35 copay); but the primary care provider copay is $25. |
| Wisconsin (WI) | None | | | | | | |
| Wyoming (WY) | Cannot be determined | | | | | • Not clear what specific SUD treatment benefits are offered. | |

# Appendix C

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Alabama (AL) | Inadequate | • "Services related to narcotic maintenance therapy such as methadone maintenance therapy," are excluded. | • All inpatient hospital admissions require prior authorization (not specific to SUD). | • Inpatient treatment is limited to 30 days per calendar year when services are rendered by provider participating in the Expanded Psychiatric Services (EPS) Program and 30 days per 12 consecutive month period if services are rendered by non-EPS providers.<br><br>• Outpatient SUD treatment is limited to 20 days per calendar year for services from non-EPS providers and 30 days per year for services from EPS providers.<br><br>*Unclear whether limit on outpatient care by EPS provider is separate from or a part of the limit on inpatient care.* | 2 | | • Plan documents silent on intermediate treatment (intensive outpatient/partial hospitalization).<br><br>• Unclear whether residential treatment is always excluded or only when care is coordinated by a non EPS provider. |
| Alaska (AK) | Inadequate | • Only covered SUD service is emergency detox. | • Not specified. | | 1<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Arizona (AZ) | Adequacy cannot be determined | | • Inpatient substance abuse services require prior authorization. | | 3<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Arkansas (AR) | Inadequate | • "Medications used to sustain or support an addiction or substance dependency are not covered." | • Many health interventions for the treatment of substance abuse are subject to prior approval, including outpatient services beyond the eighth session. | | 2 | | • Coverage for long term residential treatment for mental health is excluded; coverage for SUD residential treatment is not addressed. |
| California (CA) | Inadequate | | • Do not need prior authorization from participating chemical dependency specialists. | | 1<br>*Methadone not listed.* | • $400 per day copay for inpatient detoxification. | • Plan documents silent on methadone coverage. |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents)* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Colorado (CO) | Inadequate | | • Prior authorization requirements not specified.<br><br>• Counseling for a patient who is not responsive to therapeutic management is not covered (*limit based on past treatment response*). | | 1<br>*Methadone not listed.* | • $750 copay/admission for inpatient detox and residential treatment program. | • Plan documents silent on methadone coverage. |
| Connecticut (CT) | Inadequate | | • Hospital admissions, partial hospitalization, residential treatment, intensive outpatient programs for SUD and outpatient treatment of opioid disorders are subject to prior authorization. | | 2<br>*Methadone not listed.* | | • Unclear whether residential treatment is covered for SUD - appears to only be covered for individuals with "emotional disturbances."<br><br>• Plan documents silent on methadone coverage. |
| Delaware (DE) | Inadequate | • No coverage for residential care.<br><br>• Methadone is excluded. | • Prior authorization is required for inpatient care, intensive outpatient treatment and partial hospitalization. | | 2 | | |
| District of Columbia (DC) | Inadequate | | • Prior authorization required for inpatient substance abuse services (including residential). | | 2<br>*Methadone Maintenance is explicitly covered.* | | |
| Florida (FL) | Inadequate | • Residential treatment is excluded. (Expenses for prolonged care and treatment of SUD in a specialized or inpatient residential treatment facility are excluded). | • Prior authorization is required for substance dependency care and treatment services. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Georgia (GA) | Inadequate | | • Refer to website. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Hawaii (HI) | Inadequate | | • Pre-certification is required for out-of-state residential treatment facilities. | | 2<br>*Methadone not listed.* | | • Not clear what specific levels of care are covered.<br><br>• Plan documents silent on methadone coverage. |
| Idaho (ID) | Inadequate | | • Prior authorization is required for inpatient admissions, intensive outpatient, partial hospitalization, residential treatment and outpatient psychotherapy after the tenth visit. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Illinois (IL) | Inadequate | | • Prior authorization is required for nonemergency inpatient admissions, partial hospitalization, and intensive outpatient treatment. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Indiana (IN) | Inadequate | • Residential treatment is excluded. | • Prior authorization requirements not specified. | | 3<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Iowa (IA) | Inadequate | • Residential treatment is excluded. | • Refer to website | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Kansas (KS) | Inadequate | | • Prior authorization is required for inpatient admissions. | | 2<br>*Methadone not listed.* | | • Not clear what specific levels of care are covered.<br><br>• Plan documents silent on methadone coverage. |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Kentucky (KY) | Inadequate | • Excludes "methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents." | • Prior authorization is required for inpatient services, partial hospitalization/day treatment, residential treatment, intensive outpatient and extended outpatient visits. | | 2 | | |
| Louisiana (LA) | Inadequate | | • Prior authorization is required for inpatient treatment. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Maine (ME) | Adequacy cannot be determined | | • Prior authorization is required for non-emergency inpatient substance abuse services. | | 3<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Maryland (MD) | Inadequate | | • Hospital admissions require prior authorization. | | 2<br>*Methadone Maintenance explicitly covered .* | | |
| Massachusetts (MA) | Adequacy cannot be determined | | • Prior authorization is required for inpatient care, acute residential treatment, partial hospitalization and intensive outpatient programs. | | 3<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Michigan (MI) | Inadequate | | • Prior authorization is required for non-emergency inpatient substance abuse services (including partial hospitalization and outpatient services). | • Limit of 10 days per year for inpatient SUD services and 30 visits per year for outpatient SUD services. *Note this information appears on the Michigan 2017 EHB Benchmark Plan Summary but does not appear in the Plan Documents.* | 3<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Minnesota (MN) | Inadequate | | • Prior authorization requirements not specified. | | 2<br>*Opiate replacement therapy (including methadone and buprenorphine treatment) are explicitly covered.* | | |
| Mississippi (MS) | Inadequate | • Residential treatment is excluded. | • Prior authorization is required for all substance abuse benefits. | • Limit of seven days per calendar year for inpatient alcohol and drug abuse care and 20 days per calendar year for outpatient alcohol and drug abuse care.<br><br>• Plan contains a Uniform Individual Accident and Sickness Policy Provision. | 2<br>*Methadone not listed.* | | • Not clear what specific levels of care are covered.<br><br>• Plan documents silent on methadone coverage. |
| Missouri (MO) | Inadequate | | • Contact customer service. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Montana (MT) | Inadequate | | • Inpatient care is subject to prior authorization. | | 2<br>*Methadone not listed.* | | • Not clear what intermediate services are covered.<br><br>• Plan documents silent on methadone coverage. |
| Nebraska (NE) | Inadequate | • Residential treatment is excluded. | • Inpatient services for substance dependence and abuse must be pre-certified. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Nevada (NV) | Inadequate | • Residential treatment is excluded. | • Inpatient, non-routine outpatient, and non-emergency intensive outpatient and extended outpatient visits (longer than 50 min) require prior authorization. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| New Hampshire (NH) | Inadequate | | • Prior authorization requirements not specified. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Adequacy Determination** | **Critical SUD Exclusions** | **Prior Authorization Requirements** | **Harmful Treatment Limitations** | **Coverage of opioid medications** ***(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )*** | **High cost sharing** | **Adequacy of SUD Coverage Cannot be Determined** |
| New Jersey (NJ) | Inadequate | | • All non-emergency hospital admissions require prior authorization. | | 2<br>*Methadone not listed.* | | • Not clear what levels of SUD services are covered.<br><br>• Plan documents silent on methadone coverage. |
| New Mexico (NM) | Inadequate | | • Acute detoxification as an inpatient hospital service requires prior authorization. | • Limit on smoking cessation pharmacotherapy to two 90-day courses of treatment per calendar year (*restrictive limit on smoking cessation services* ). | 2<br>*Methadone not listed.* | | • Acute detoxification as inpatient hospital and residential are the only services mentioned - not clear what other SUD services are covered.<br><br>• Plan documents silent on methadone coverage. |
| New York (NY) | Inadequate | | • Prior authorization requirements not specified. | | 2<br>*Methadone not listed.* | | • No mention of intermediate level services. Plan documents state inpatient rehabilitation services are covered but do not explicitly address residential services.<br><br>• Plan documents silent on methadone coverage. |
| North Carolina (NC) | Inadequate | | • Inpatient, partial hospitalization and intensive outpatient SUD services require prior authorization. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| North Dakota (ND) | Inadequate | • Benefits available for residential treatment for members under age 21; no benefits for residential treatments for psychiatric illness or SUD for ages 21 and over. | • Prior authorization is required for inpatient SUD services, residential, partial hospitalization and intensive outpatient services. | • Tobacco cessation services limited to Maximum Benefit Allowance of two quit attempt cycles per Benefit Period (4 counseling sessions; 3 month supply of NRT products) (*restrictive limit on smoking cessation services* ). | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Ohio (OH) | Cannot be Determined | | • Prior authorization requirements not specified. | | 3<br>*Methadone not listed.* | | • Not clear what specific SUD treatment benefits are offered.<br><br>• Plan documents silent on methadone coverage. |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Oklahoma (OK) | Inadequate | | • Prior authorization is required for inpatient SUD services and intensive outpatient treatment. | | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Oregon (OR) | Inadequate | | • As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these. | • 45 day limit on residential treatment. | 2<br>*Methadone not listed.* | | • Plan documents do not clearly address the types of SUD services that are covered.<br><br>• Plan documents silent on methadone coverage. |
| Pennsylvania (PA) | Inadequate | | • Refer to website. | | 2<br>*Methadone not listed.* | • $500 copay/day up to $2,500 max per admission (residential and inpatient). | • Plan documents do not clearly address smoking cessation services.<br><br>• Plan documents silent on methadone coverage. |
| Rhode Island (RI) | Inadequate | • Methadone clinics and treatment are not covered. | • Prior authorization recommended for inpatient substance abuse treatment. | | 2 | | |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| South Carolina (SC) | Inadequate | • Residential treatment excluded | • Prior authorization is required for inpatient and outpatient SUD services. | • Imposes a limit of seven days per benefit period for inpatient SUD services and 25 visits per benefit period for outpatient/office visits for mental health services/substance abuse care (combined). *Note this information appears on the South Carolina 2017 EHB Benchmark Plan Summary but does not appear in the Plan Documents*<br><br>• Plan documents contain a Uniform Individual Accident and Sickness Policy Provision | 3<br>*Methadone not listed.* | | • Not clear what specific SUD treatment benefits are offered.<br><br>• Plan documents silent on methadone coverage. |
| South Dakota (SD) | Inadequate | • Residential treatment excluded. | • Refer to website. | • Limit of 30 days per six-month period for inpatient treatment and 90 days per lifetime for inpatient treatment for alcoholism treatment.<br>• Inpatient treatment for all other substance abuse services limited to 30 days per benefit year. | 1<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Tennessee (TN) | Inadequate | • The exclusion for "maintenance care" applies to drugs used to treat chemical dependency. The pharmacy benefit includes an exclusion for "prescription drugs used during maintenance phase of chemical dependency treatment unless Authorized by" the plan. | • Prior authorization is required for inpatient levels of care, including, acute care, residential treatment, partial hospital care and intensive outpatient services. | | 2 | | |
| Texas (TX) | Inadequate | • Residential treatment excluded. | • Prior authorization is required for the treatment of chemical dependency and specifically for inpatient treatment and intensive outpatient programs. | • Maximum lifetime benefit of three separate series of SUD inpatient treatments. | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Utah (UT) | Inadequate | • Residential treatment excluded. | • Inpatient benefits for mental health require prior authorization (SUD benefits are listed under mental health benefits). | | 2<br>*Methadone not listed.* | | • SUD services not specified (only mental health services).<br><br>• Plan documents silent on methadone coverage. |
| Vermont (VT) | Inadequate | | • Prior authorization is required for inpatient or partial-inpatient substance abuse services, and intensive outpatient services and residential services. | • Covers short term residential treatment (not defined). | 2<br>*Methadone not listed.* | | • Plan documents silent on methadone coverage. |
| Virginia (VA) | Adequacy cannot be determined | | • Prior authorization requirements not specified. | | 3<br>*Methadone not listed.* | • $500 copay per day/$1500 max per admission (inpatient and residential treatment center services). | • Plan documents silent on methadone coverage. |
| Washington (WA) | Inadequate | | • Prior authorization requirements not specified. | | 2<br>*Methadone not listed.* | | • No specific benefit information provided.<br><br>• Plan documents silent on methadone coverage. |
| West Virginia (WV) | Inadequate | • Residential treatment is excluded. | • Refer to website. | | 2<br>*Methadone not listed.* | | • Only mentions residential. Intermediate level services (intensive outpatient, partial hospitalization) not addressed.<br><br>• Plan documents silent on methadone coverage. |
| Wisconsin (WI) | Inadequate | • Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents" are excluded from SUD Services. | • Inpatient, partial hospitalization, residential treatment, intensive outpatient and extended outpatient visits (beyond 45-50 mins) are subject to prior authorization. | | 2 | | |

| State | Inadequate SUD Benefits | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adequacy Determination | Critical SUD Exclusions | Prior Authorization Requirements | Harmful Treatment Limitations | Coverage of opioid medications *(Number represents the number of submission of Opioid Dependence Treatment Medications from CMS benchmark summaries. Methadone information is from plan documents )* | High cost sharing | Adequacy of SUD Coverage Cannot be Determined |
| Wyoming (WY) | Inadequate | | • Prior authorization requirements not specified. | | 2<br>*Methadone not listed.* | | • Not clear what specific SUD treatment benefits are offered.<br><br>• Plan documents silent on methadone coverage. |

# ENDNOTES

[1] Essential health benefits package. 42 U.S.C. § 300gg-6(a) (2010).
Establishment of qualified health plans. Essential health benefits requirement. 42 U.S.C. § 18022 (2010).
[2] 42 U.S.C. § 18022(b)(1) (2010).
Health insurance issuer standards under the Affordable Care Act, including standards relating to exchanges, essential health benefits. Provision of EHB. 45 C.F.R. § 156.115(a)(3) (2015).
[3] 42 U.S.C. § 18022(b)(1) (2010).
[4] 42 U.S.C. § 300gg-6(a) (2010).
No lifetime or annual limits. Prohibition. 42 U.S.C. § 300gg-11(a) (2010).
[5] Final rules under the Paul Wellstone and Pete Domencini Mental Health Parity and Addiction Equity Act of 2008. 78 Fed. Reg. 68,240, 68,254 (Nov. 13, 2013).
[6] 78 Fed. Reg. 68,240, 68,254 (Nov. 13, 2013).
[7] Coverage of preventive health services. 42 U.S.C. § 300gg-13 (2010).
Coverage of preventive health services. 45 C.F.R. § 147.130(a)(i), (iii) (2011).
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Patient Protection and Affordable Care Act. HHS notice of benefit and payment parameters for 2016; final rule. 80 Fed. Reg. 10,750, 10,815 (Feb. 27, 2015).
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[14] The U.S. Pharmacopeial Convention. (2016). *USP Medicare model guidelines v.6.0*. Retrieved from http://www.usp.org/sites/default/files/usp_pdf/EN/uspmmg_v6_0_w_exampledrugs_rev140415.pdf.
[15] Beneficiary protections for qualified prescription drug coverage. 42 U.S.C. § 1395w-104(b)(3)(C)(ii) (2010).
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[16] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2016). *Medicare prescription drug benefit manual, chapter 6 – part D drugs and formulary requirements*. Retrieved from https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/chapter6.pdf.
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Medication assisted treatment for opioid use disorders. 81 Fed. Reg. 17,639, 17,643 (Mar. 30, 2016).
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[18] Health insurance issuer standards under the Affordable Care Act, including standards relating to exchanges, essential health benefits. State selection of benchmark. 45 C.F.R. § 156.100 (2015).
Centers for Medicare & Medicaid Services. (2011). *Essential Health Benefits Bulletin*. Retrieved from https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.
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[20] Health insurance issuer standards under the Affordable Care Act, including standards relating to exchanges, essential health benefits. EHB-benchmark plan standards. 45 C.F.R. §§ 156.110 (2015).
[21] 45 C.F.R. §§ 156.110(d) (2015).
Health insurance issuer standards under the Affordable Care Act, including standards relating to exchanges, essential health benefits. Prohibition on discrimination. 45 C.F.R. § 156.125 (2015).
Health insurance issuer standards under the Affordable Care Act, including standards relating to exchanges. Qualified health plan minimum certification standards, QHP issuer participation standards. 45 C.F.R. § 156.200(e) (2016).
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[27] 45 C.F.R. § 146.136(c)(2)(ii) (2011).
78 Fed. Reg. 68,240, 68,246-47 (Nov. 13, 2013).
[28] 78 Fed. Reg. 68,240, 68,241 (Nov. 13, 2013).
[29] 45 C.F.R. § 146.136(c)(2)(ii) (2011).
[30] 45 C.F.R. § 146.136(c)(3) (2011).
78 Fed. Reg. 68,240, 68,269 (Nov. 13, 2013).
[31] 45 C.F.R. § 146.136(c)(4) (2011).
[32] 78 Fed. Reg. 68,240, 68,245 (Nov. 13, 2013).
[33] 45 C.F.R. § 146.136 (2011).
[34] 45 C.F.R. § 146.136(b)(2) (2011).
[35] 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015).
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