Short Paper #3

The ACA and Substance Use Disorders
December 2010

Prepared by: Corey Davis

Background

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act ("ACA" or "the Act") into law.[1] While the ACA is aimed primarily at improving health outcomes by increasing access to health insurance, it also contains a number of provisions targeted at improving health through other means. This short paper discusses three that are likely to improve access to programs and services to prevent and treat substance use disorder (SUD).[2] One makes such services part of the "essential benefit" package that most plans covering newly insured people will be required to offer. The second requires that these benefits be provided at parity with medical and surgical services, while the third prohibits insurers from refusing to cover people with a history of SUD.

The Essential Health Benefits Requirement

Many insurance plans, particularly those available to lower income people, provide poor or no coverage for SUD treatment.[3] The ACA changes that. Beginning January 1, 2014, the health insurance plans offered to most newly insured (and many currently insured) people must provide "essential health benefits."[4] Among these essential benefits is coverage for mental health and substance use disorder services.[5] The Department of Health and Human Services

---

[1] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter ACA].

[2] Although the DSM-IV identifies both "substance abuse" and "substance dependence" disorders, this paper will use the term "substance use disorder," following recent trends in the field. *See* Am. Psychiatric Ass'n, *Substance-Use Disorder*, American Psychiatric Association DSM-5 Development, http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=431# (last visited Dec. 5, 2010).

[3] Nat'l Alliance on Mental Illness and Nat'l Council for Community Behavioral Healthcare, *Coverage for All: Inclusion of Mental Illness and Substance Use Disorders in State Health Care Reform* 7 (June 2008) (finding that only 28% of surveyed states have at least one program for the uninsured that provides SUD services at parity).

[4] ACA § 1301(a)(1)(B) (codified at 42 U.S.C.A. §18021 (West 2010)).

[5] The required services are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management;

(DHHS) will issue guidance and regulations that will provide specifics as to the scope of these benefits.[6] At DHHS' request, the Institute of Medicine will make recommendations on the criteria and methods for determining and updating the essential health benefits package.[7]

These essential health benefits must be part of the coverage offered by all qualified health plans within health insurance exchanges.[8] State-sponsored basic health programs and small group and individual plans offered outside of an exchange must meet the standard as well, as will plans covering most persons enrolled under the expanded Medicaid coverage rules that will go into effect in 2014.[9]

The Substance Use Disorder Parity Requirement

The ACA improves access to substance use disorder services by extending a federal law that requires that SUD benefits be provided at parity with medical and surgical benefits to most people who will gain insurance under the Act. All plans offered through exchanges and all benchmark and benchmark-equivalent Medicaid plans will be required to comply with this law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).[10] While the MHPAEA does not apply to traditional fee for service Medicaid, it does apply to Medicaid plans operated by managed care organizations.[11]

---

and pediatric services including oral and vision care. ACA § 1302(b)(1)(A-J) (codified at 42 U.S.C.A. § 18022(b)(1)(A-J) (West 2010)).

[6] When making the determination of what services the essential health benefits provision will encompass, DHHS is required to take into account a number of factors, including "the health care needs of diverse segments of the population , including women, children, persons with disabilities, and other groups" ACA § 1302(b)(4)(C) (codified at 42 U.S.C.A. § 18022(b)(4)(C) (West 2010)). Notice and opportunity for public comment on these determinations must be provided, although no formal rulemaking procedure is specified. *Id*. at § 1302(b)(3) (codified at 42 U.S.C.A. § 18022(b)(3) (West 2010)).

[7] The IOM is to "provide guidance on the policy principles and criteria for the Secretary to take into account when examining [qualified health plans] for appropriate balance among categories of care; the health care needs of diverse segments of the population; and nondiscrimination based on age, disability, or expected length of life; and offer advice on criteria and a process for periodically reviewing and updating the benefits package." Institute of Medicine, *Determination of Essential Health Benefits* (December 21, 2010, 9:27 AM), http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx.

[8] ACA § 1301(a)(1)(B) (codified at 42 U.S.C.A. §18021 (West 2010)).

[9] *Id.* at § 1201 (amending 42 U.S.C. 300gg-6) (individual and small group market); *Id.* at § 2001(c) (amending 42 U.S.C. 1396u-7(b)) (Medicaid). Some categories of newly eligible people will be enrolled in traditional fee for service Medicaid plans, which are not required to cover essential health benefits. *Id.* at § 2001(a)(2) (adding 42 U.S.C. § 1396a(k)(1)). These categories are listed in 42 U.S.C. § 1396u-7(a)(2)(B) (2006).

[10] ACA § 1311(j) (codified at 42 U.S.C.A. § 1396u-7(b)(6)(A) (West 2010)).

[11] *See* 42 U.S.C. § 1396u-2(b)(8) (2006) ("Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer

The MHPAEA was enacted in 2008 as part of a larger piece of legislation, the Emergency Economic Stabilization Act of 2008.[12] It builds on and extends a 1996 law, the Mental Health Parity Act (MHPA).[13] The MHPA took a first step in the direction of parity by prohibiting group health plans from imposing annual or lifetime dollar limits on mental health benefits except to the extent that such limits were also imposed on medical and surgical benefits.[14] While the MHPA did improve access to services for some mental health conditions, SUD benefits were excluded from its reach.[15]

The MHPAEA improves on the MHPA in several respects.[16] It extends the scope of covered conditions to include SUD and prohibits plans that offer both medical/surgical benefits and SUD benefits from charging higher deductibles or copayments for SUD services than those charged for medical/surgical services.[17] It also prohibits plans from limiting the number or frequency of provider visits for SUD except to the extent that those limits are also imposed on substantially all medical and surgical benefits and requires that plans that provide out-of-network medical/surgical benefits also provide out-of-network SUD treatment.[18] Finally, regulations promulgated under the MHPAEA require that health plans that offer benefits for a specific substance use condition in any one of six classifications (inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs) also provide benefits for that condition in every other classification in which medical/surgical benefits are offered.[19]

The Prohibition on Pre-existing Condition Exclusions

Federal law does not currently prohibit health insurance plans from denying coverage to persons with a history of substance use disorder or from charging such persons prohibitively high premiums. The ACA tackles this problem in two ways. First, it requires the establishment of Pre-existing Condition Insurance Pools (PCIPs) to enroll persons who have been uninsured for at

---

that offers group health insurance coverage."). The MHPAEA does not apply to group health plans sold to employers with fewer than 50 employees or to plans in the individual market. *See* 29 U.S.C.A. § 1185a(c)(1) (West 2010).

[12] Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, 122 Stat. 3881 (2008) (amending 29 U.S.C. 1185a).

[13] Mental Health Parity Act of 1996, Pub .L. 104-204, 110 Stat. 244 (1996) (codified as amended at 29 U.S.C. § 1185a).

[14] *Id*.

[15] 29 U.S.C. § 1185a(e)(4) (2006), *amended by* Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, 122 Stat. 3881 (2008).

[16] The MHPAEA does not require that SUD benefits be provided; it only requires that when offered they are provided at parity. SUD benefits, are, however, one of the required essential health benefits that must be provided to most people who will gain health insurance as a result of the ACA. *See* n.5, *supra*, and accompanying text.

[17] Pub. L. No. 110-343, § 512(a), (adding §(3)(A)(i) to 29 U.S.C. 1185a).

[18] *Id.* (adding § (3)(A)(ii) and §(5) to 29 U.S.C. 1185a).

[19] *See* Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5433 (Feb. 2, 2010).

least six months and are having difficulty enrolling in insurance plans because of a pre-existing condition.[20] These PCIP plans will terminate on January 1, 2014, when a broad exclusion on denying coverage on the basis of pre-existing conditions will go into effect.[21]

Beginning in 2014, group health plans and issuers that offer group or individual health insurance coverage are prohibited from denying coverage to people over the age of 18 because of pre-existing conditions or discriminating against individuals who have a history of illness.[22] This prohibition goes into effect for enrollees under age 19 for plan years beginning on or after September 23, 2010.[23] The provision also prohibits individual and small group policies from charging higher rates because of an enrollee's health status.[24] Additionally, most insurers will be prohibited from imposing lifetime and annual limits on the dollar value of essential health benefits.[25]

Other Provisions Affecting Substance Use Disorder Prevention and Treatment

Other ACA provisions could potentially impact SUD services in less direct ways. For example, beginning in 2011 states will have the option to amend their state Medicaid plans to incorporate "health homes" for individuals with chronic conditions.[26] Substance use disorder is specifically listed as a chronic condition, and states that pursue this option are required to consult and coordinate with the Substance Abuse and Mental Health Services Administration to address "issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions."[27] The health home model is designed to increase collaboration between providers and coordinate disease prevention and management in a way that is more responsive to the patient's needs. Since SUD treatment particularly for those with concurrent conditions is often hampered by lack of coordination between providers, such a health home may improve the quality of care such people receive.

---

[20] ACA § 1101(a).
[21] *Id.* at § 1101(g)(3).
[22] ACA § 1201 (amending 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4).
[23] *Id. See also* Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule, 75 Fed. Reg. 37187, 37190 (June 28, 2010).
[24] ACA § 1201 (amending 42 U.S.C. § § 300gg).
[25] ACA §§ 1001, 10101 (amending 42 U.S.C. § 300gg-11). Plans may still impose annual and lifetime limits on non-essential health benefits. *See id.* at § 10101(a).
[26] ACA § 2703(a) (amending 42 U.S.C 1396w-4). An "eligible individual" is someone who is eligible for Medicaid and has at least two chronic conditions, one chronic condition and is at risk of having a second chronic condition, or one serious and persistent mental health condition. Chronic conditions include, but are not limited to, mental health conditions, substance use disorders, asthma, diabetes, heart disease, and a Body Mass Index over 25. *Id.*
[27] *Id.*

Many other ACA provisions may be helpful in the prevention and treatment of SUD as well.[28] For example, some SUDs begin with improper or inadequate pain treatment or attempts to self-medicate depressive disorders.[29] The ACA provides funds to advance research and treatment for pain care and allocates funding for better pain care treatment.[30] It also creates Centers of Excellence for Depression and provides over one billion dollars of funding for research into and treatment of depressive disorders.[31] Additionally, the ACA establishes several funding streams for investment in prevention programs, which should include the prevention of SUD.[32] Although there is no direct funding stream for SUD treatment, it is not inconceivable that grants under some of these funding initiatives could be used for SUD treatment if evidence exists that such treatment prevents other diseases and conditions.

Conclusion

The ACA should improve access to treatment for substance use disorders in a number of ways. Chief among these are the extension of health insurance including SUD coverage to many previously uninsured people and requirements that most health plans covering these newly insured people provide coverage for SUD at parity with medical and surgical care, together with a ban on refusing coverage to persons because of a previous SUD diagnosis. Many other aspects of the ACA should also work to help prevent and treat SUD, and some funding may be available to prevent its occurrence.

For further information, please contact:
Corey Davis
davis@healthlaw.org
www.healthlaw.org

[28] For a chart of the ACA's main public health provisions, *see* Corey Davis & Sarah Somers, *Public Health Provisions of the Patient Protection and Affordable Care Act* (October 2010), http://www.publichealthlawnetwork.org/wp-content/uploads/ACA-chart-formatted-FINAL2.pdf.
[29] *See* Jane C. Ballantyne & K. Steven LaForge, *Opioid dependence and addiction during opioid treatment of chronic pain*, 129. PAIN 235, 249 (2007) (stating that "it is generally recognized that problematic opioid seeking and addiction arise often enough during chronic treatment to be of considerable concern."); *see also* Arthur W. Blume, Karen B. Schmaling, and G. Alan Marlatt, *Revisiting the self-medication hypothesis from a behavioral perspective*, 7 COGNITIVE AND BEHAVIORAL PRACTICE 379, 381 (2000) (finding hierarchical logistic regression analyses support conclusion that depressive disorder is associated with both self-medication and symptom exacerbation hypotheses).
[30] ACA § 4305 (codified at 42 U.S.C.A. § 284a; 42 U.S.C.A § 294i (West 2010)).
[31] *Id.* at § 10410 (codified at 42 U.S.C.A. § 290bb–33 (West 2010)).
[32] The largest of these, the Prevention and Public Health Fund, is appropriated increasing amounts beginning with $500 million in FY 2010 up to $2 billion in FY2015 and thereafter. ACA § 4002 (codified at 42 U.S.C.A. § 300u–11 (West 2010)).