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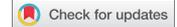


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ORIGINAL ARTICLE



Benefit requirements for substance use disorder treatment in state health insurance exchanges

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ABSTRACT

Background: Established in 2014, state health insurance exchanges have greatly expanded substance use disorder (SUD) treatment coverage in the United States as qualified health plans (QHPs) within the exchanges are required to conform to parity provisions laid out by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act (MHPAEA). Coverage improvements, however, have not been even as states have wide discretion over how they meet these regulations. **Objective:** How states regulate SUD treatment benefits offered by QHPs has implications for the accessibility and quality of care. In this study, we assessed the extent to which state insurance departments regulate the types of SUD services and medications plans must provide, as well as their use of utilization controls. **Methods:** Data were collected as part of the National Drug Abuse Treatment System Survey, a nationally-representative, longitudinal study of substance use disorder treatment. Data were obtained from state Departments of Insurance via a 15-minute internet-based survey. **Results:** States varied widely in regulations on QHPs' administration of SUD treatment benefits. Some states required plans to cover all 11 SUD treatment services and medications we assessed in the study, whereas others did not require plans to cover anything at all. Nearly all states allowed the plans to employ utilization controls, but reported little guidance regarding how they should be used. **Conclusion:** Although some states have taken full advantage of the health insurance exchanges to increase access to SUD treatment, others seem to have done the bare minimum required by the ACA. By not requiring coverage for the entire SUD continuum of care, states are hindering client access to appropriate types of care necessary for recovery.

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Introduction

State health insurance exchanges have significantly expanded the number of Americans with coverage for substance use disorder (SUD) treatment. Established in 2014 as part of the Affordable Care Act (ACA), the exchanges are administered by federal and state governments. Within each exchange, for- and non-profit private insurers may offer qualified health plans (QHPs) that meet federally outlined standards of consumer protection, including coverage of “essential health benefits” (EHBs) including SUD treatment (1,2). Moreover, exchanges are required under the ACA to comply with parity provisions stipulated in the Mental Health Parity and Addiction Equity Act (MHPAEA) (3,4), which require that benefits for SUD treatment are comparable to benefits for other medical and surgical services. In

2016, 9.2 million people received health insurance through one of over 200 QHPs participating in the exchanges (5).

These efforts to improve SUD treatment benefits, however, have not been uniform. States have substantial discretion over how they meet these regulations. Under the ACA, states were allowed to designate an EHB benchmark plan—typically the largest of each state's small group insurance plans or government health plans. SUD treatment benefits as outlined within the selected benchmark plan determine the coverage standards that QHPs have to meet or exceed (6). How states are regulating SUD treatment benefits provided by QHPs, both in terms of the specific services that are covered, and the use of utilization controls on services such as preauthorization, has substantial implications for the accessibility and quality of

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care. Accordingly, the present study investigates whether state insurance departments require QHPs to cover specific SUD services, and whether states place any restrictions on how QHPs can impose various utilization controls.

Methods

Data collection

Data were collected as part of the sixth wave of the National Drug Abuse Treatment System Survey (7), a nationally-representative, longitudinal study of health reform on the provision of SUD services and benefits. This study focuses exclusively on data obtained from state Departments of Insurance. Public directories were used to identify appropriate respondents from each Department of Insurance in all 50 states and the District of Columbia. Recruitment letters were sent to insurance commissioners detailing the aims of the study and how to access the 15-minute survey online. Follow-up contact was initiated by the research team for non-responders. Data were collected between November 2013 and July 2014. A 92% response rate was achieved. For four non-responding states, we completed survey items using public information when available. All study procedures were approved by the authors' affiliated Institutional Review Boards.

Measures

The survey asked a series of questions on SUD treatment benefits requirements and regulation of utilization controls. SUD services assessed by the survey—individual outpatient, group outpatient, intensive outpatient, detoxification, short-term residential, long-term residential, and recovery support services—were based on American Society of Addiction Medicine (8) criteria, a national guideline for an evidence-based continuum of care for SUD treatment. The survey also included questions about benefits for methadone, oral and injectable naltrexone, and buprenorphine—four evidence-based, FDA-approved medications for SUD treatment. For each SUD service or medication, respondents were asked to select one of three possible responses: “required,” “not required,” or “not specified.” The third response option, “not specified,” was added because we discovered in follow-up calls to address non-response that several states were leaving the item blank because their state did not specify how QHPs should cover SUD services; thus, it was neither “required” nor explicitly “not required.” Similarly, our phone discussions revealed that for questions relating

to utilization controls, a blank response meant that their state does not specify what QHPs can or cannot do regarding utilization controls. Thus, in addition to “yes” or “no” response choices for these questions, a “no response” option was added as well.

SUD treatment benefits and utilization controls may also vary based on the type of EHB benchmark plan designated by states. Due to the low number of states that have designated non-small group plans as their benchmark, however, there was very little variability across the benchmark types on coverage. For years 2014–2016, 44 states and the District of Columbia selected small group plans, four selected commercial HMOs, and only two states opted for state employee plans as their EHB benchmarks. This has remained largely unchanged in 2017 with 46 states and including the District of Columbia designating small group plans, one state selecting a commercial HMO, and three selecting state employee plans as their benchmarks. In addition, we examined differences in SUD treatment benefits and utilization controls by health insurance exchange type (federal, state, and federal/state partnerships). There were no significant differences in these state policies by exchange type, therefore these results are not reported.

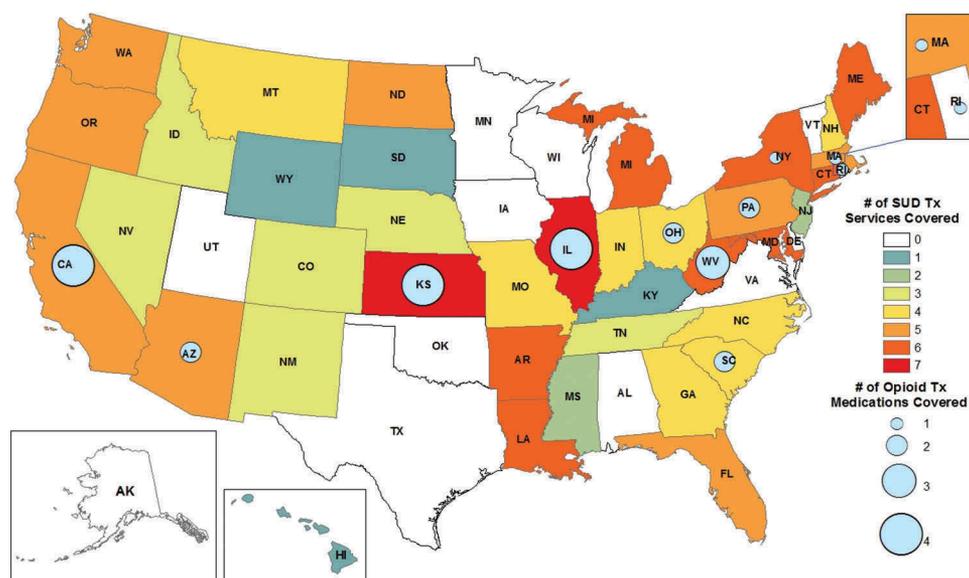
Results

Benefits for SUD treatment varied across states (See Table 1). Individual outpatient (70.6% of states) was the most frequently required SUD service benefit. Long-term residential (25.5%) and recovery support services (9.8%) were the least often required. Requirements for SUD treatment medications were much less common with only 11 states (21.6%) requiring any opioid treatment coverage: oral naltrexone (15.7%) was most frequently required and buprenorphine (9.8%) was least frequently required. Only seven states (13.7%) required coverage for a combination of seven or more SUD services and/or medications (See Figure 1). Among those seven states, only two (3.9%)—Illinois and Kansas—required the full range of seven ASAM services and all four opioid treatment medications. This was followed by New York and West Virginia, both of which required six treatment services along with one and three medications, respectively. California required coverage for five services and all four medications, whereas both Arizona and Pennsylvania required five services and only two medications.

Nineteen states and the District of Columbia (39.2%) required coverage for 4–6 SUD services and/or medications. Thirteen states (25.5%) required 1–3 service(s) and/or medication(s). Remarkably, 21.1% of states did

Table 1. Substance use disorder treatment benefits coverage required by states.

Service (N = 51)	Required %(N)	Not Required %(N)	Not Specified %(N)
Individual outpatient	70.6 (36)	3.9 (2)	25.5 (13)
Group outpatient	60.8 (31)	5.9 (3)	33.3 (17)
Intensive outpatient	45.1 (23)	5.9 (3)	49.0 (25)
Detoxification	58.8 (30)	2.0 (1)	39.2 (20)
Short-term residential	54.9 (28)	7.8 (4)	37.3 (19)
Long-term residential	25.5 (13)	23.5 (12)	51.0 (26)
Recovery support services	9.8 (5)	7.8 (4)	82.4 (42)
Medication (N = 51)			
Methadone maintenance	13.7 (7)	15.7 (8)	70.6 (36)
Oral naltrexone	15.7 (8)	7.8 (4)	76.5 (39)
Injectable naltrexone	11.8 (6)	9.8 (5)	78.4 (40)
Buprenorphine	9.8 (5)	3.9 (2)	86.3 (44)
Any medication required	21.6 (11)	N/A	N/A

**Figure 1.** State requirements for substance use disorder treatment services and medications coverage by qualified health plans.

not require QHPs to provide any particular set of benefits for SUD treatment.

Forty-six states and the District of Columbia (92.2%) allow QHPs to place utilization controls on SUD services (See Table 2). Of those 47, 37 states and the District of Columbia allow QHPs full discretion over utilization controls without any specifications. Only nine states set specifications on the ways in which utilization controls may be imposed by QHPs.

Discussion

This study identified large variation in benefits for SUD treatment across the states. Although some states have taken full advantage of the health insurance exchanges to increase access to SUD treatment, others seem to have done the bare minimum required by the ACA. Approximately one in five states did not require QHPs operating in their jurisdiction to offer any particular SUD services or medications, despite SUD services

being an EHB under the ACA. An additional 25% of states covered fewer than four services, most typically, a combination of outpatient treatment and detoxification. Given a growing consensus regarding the need to establish a continuum of care for the treatment of SUD that includes multiple levels of care, the absence of benefits for more intensive forms of treatment and recovery services in most states, raises concerns about whether the needs of the population with SUDs are being met.

SUD treatment medication coverage is required by states even more rarely than psychosocial services. In the midst of an escalating opioid epidemic, most states do not require QHPs to provide benefits for evidence-based medications for treatment of opioid use disorder treatment such as buprenorphine, injectable naltrexone, and methadone.

Similarly, the vast majority of insurance departments allow QHPs to impose utilization controls on any covered SUD services or medications. These findings indicate a

Table 2. Utilization controls allowed by states.

Utilization Controls (N = 51)	Yes %(N)	No %(N)	No Response %(N)	Not Applicable* %(N)
Does your state allow QHPs to place utilization controls on substance abuse treatment services?	80.4 (41)	7.8 (4)	11.8 (6)	0
Does your state allow QHPs to vary with regard to the utilization controls they place on substance abuse treatment services?	49.0 (25)	17.6 (9)	25.5 (13)	7.8 (4)

*This includes services not required and if the state does not allow QHPs to impose utilization controls.

hands-off policy in most states under which QHPs are given full discretion to decide how to comply with the EHB provision and parity requirements under the ACA and the MHPAEA. This finding is somewhat in contrast to findings from a 2017 study (9) that also examined state SUD benefits coverage but within the context of Medicaid. State Medicaid programs were more likely to specify required coverage for both SUD treatment services and medications. Whereas 19 state Medicaid plans offered the full range of ASAM levels of care and opioid use disorder medications, only two state marketplace plans provide comprehensive ASAM services and medication coverage. However, like QHPs, the majority of Medicaid plans imposed utilization controls. In addition, both QHPs and Medicaid plans did not uniformly require the full spectrum of SUD treatment services and medications necessary for recovery.

A shortcoming of this study is that our survey did not include data on state insurance commissions' enforcement of parity provisions as stipulated by the ACA and MHPAEA. The lack of parity enforcement data could be a factor influencing our findings. However, given that the health exchanges were just getting implemented in January of 2014 and states were still trying to figure out the particulars of their respective marketplaces, it is likely that parity enforcement was not yet fully established during our study period.

Conclusion

Adequate SUD treatment benefits are a critical component of a public health response to addiction. There is a need for states to provide greater clarity to QHPs and the public regarding what SUD services and medications are covered by QHPs. Ideally, states would regulate what the minimum set of SUD benefits should be. That way, when people with SUDs (and parents of children with SUDs) are choosing a QHP on their state exchange, they can at least know what SUD services and medications should be covered across all the QHPs, and focus on whether some plans offer more coverage and at what price. In the absence of a "minimum SUD benefit" regulation, states should be required to provide clear information about the exact SUD services and benefits covered

under each plan, and whether any utilization controls are imposed.

Presently, the future of the ACA is uncertain. It is important to consider the potential effect that dismantling the ACA would have on SUD benefits. The largest negative impact of repeal would be an increase in the number of uninsured Americans to over 20 million including 2 million (10) with a SUD (11). In addition, extended parity benefits through the ACA would be reversed. Essential health benefits, in which SUD treatment is included, would be quashed. Also, loss of Medicaid Expansion funding would place a heavier burden on states to finance substance abuse treatment. Furthermore, the elimination of federal subsidies would lead to additional financial barriers to SUD treatment access. Regardless of the ACA's outcome, states will still be faced with the task of better communicating to insurers and the public about the details of SUD benefit packages under state regulated plans.

Declaration of interest

The authors report no relevant financial conflicts.

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