Public Policy Statement on Parity in Publicly Funded Health Insurance Benefits for Treatment of Addiction

Background

The American Society of Addiction Medicine has well-established policy affirming that alcohol and other drug addictions are diseases; that patients in a variety of medical, surgical, and emergency room settings should be screened to provide early identification of cases of addiction to alcohol or other drugs; that treatment for alcohol and other drug dependence is effective and should include a continuum of services; and that when established utilization management criteria such as the ASAM Patient Placement Criteria are used to determine the appropriateness of placement in a given level of addiction treatment, then insurance benefits should be applicable to any of those levels of care. ASAM policy also affirms that addiction treatment should be accessible to patients regardless of gender, age, or geographic locale, and that insurance benefits that cover addiction treatment should be at a par with insurance benefits for other health conditions.

1 This Public Policy Statement replaces the 2004 Public Policy Statement on Eliminating Disparities in Medicare and Medicaid for Addiction Treatment.


3 ASAM Public Policy Statement on Screening for Addiction in Primary Care Settings, April 1997; rev. October 1997


7 ASAM Public Policy Statement on the Core Benefit for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence, April 1993; and ASAM Public Policy Statement on Parity in Insurance Benefit Structure between General Medical Services and Services for the Evaluation, Management and Prevention of Behavioral Health Conditions, including Addictive Disorders, October 2002
However, in the early part of the 21st century, parity in health insurance benefits for addiction services is not the norm in either private sector or government-operated health insurance plans. The enactment in 2008 of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act promises to redress these inequities in private sector health insurance plans (employer-based and union-based plans and individually-owned policies) and in Medicaid managed care plans. But further reforms are necessary to achieve parity in other aspects of publicly financed health insurance plans and systems of care.

Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act define “substance abuse services” as covered services under these governmental health insurance plans, but not at a par with coverage for other medical/surgical services. The result is that patients with diseases (e.g., Huntington's chorea) affecting one region of their brain (caudate nucleus, putamen, globus pallidus), receive different coverage under Medicare and Medicaid for diagnostic and therapeutic health care services than patients with diseases (e.g., addiction) affecting another region of their brain (the limbic system).

Among the existing disparities between addiction and mental health disorders on the one hand and other medical conditions on the other is Medicaid’s IMD (Institutions for Mental Diseases) Exclusion. This statutory provision, enacted in 1965 at the creation of Medicaid -- long before the concepts of medical care management existed -- was an effort to avoid burdening Medicaid with financing care in large non-federal facilities and to avoid having federal dollars pay for long-term treatment or “warehousing” of patients with mental disorders in state hospitals or nursing homes. But a current consequence is that patients in the 21st century are denied coverage for the treatment of mental health or substance use disorders except in hospitals where there are fewer than 16 psychiatric beds. This prevents the treatment of patients using Medicaid dollars in cost-effective public or private specialty facilities that have evolved using hospital or residential levels of care (ASAM PPC Level IV or Level III care).

Medicare, on the other hand, will reimburse for detoxification and rehabilitation treatments in an inpatient hospital setting, but will compensate for programmatic outpatient treatment (ASAM PPC Level II care) only in the outpatient departments of licensed hospitals. Whereas single outpatient visits with a professional are a part of the benefit package, only one visit with one professional a day is compensated. Therefore, the various ambulatory programmatic levels of care defined in the ASAM Patient

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8 As defined by statute, “[t]he term ‘institution for mental diseases’ means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” Current federal law prohibits Medicaid reimbursement for any person over age 21 and under age 65 who resides in an institution for mental diseases (IMD), even for treatment unrelated to mental illness. State and private psychiatric hospitals are IMDs, as are nursing homes that specialize in caring for the severely mentally ill.
ASAM Public Policy Statement on Parity in Public and Federal Insurance Benefits for the Treatment of Addiction

Placement Criteria and in similar descriptions of the appropriate spectrum of addiction care are not provided as a benefit. The result can be repeated, expensive hospital episodes of care where less expensive residential or ambulatory services have been demonstrated to produce improved outcomes.

In the TriCare system, which is the insurer for active duty military personnel and their families as well as retired military living away from a Military Treatment Facility, although the number of providers for general medical disorders covered is large and includes out of network providers, mental health and substance use disorders are covered only for in-network providers. While TriCare was one of the first insurers to nominally recognize the ASAM Patient Placement Criteria and all its levels of care, TriCare provider networks are quite limited, and fee schedules are set so low that the availability of network providers and access to quality providers of addiction care are significantly limited. In addition, outpatient and residential services such as those described in the Criteria are not covered.

The result, again, is repeated, expensive hospital episodes of care where less expensive residential or ambulatory services have been demonstrated to produce improved outcomes. In addition, in direct opposition to the scientific literature on opioid addiction treatment, TriCare categorically excludes maintenance treatment for opioid dependence, including buprenorphine and methadone, from its benefit package.

These are only several examples of how medical diseases including psychiatric and addictive disorders are treated differently than other medical disorders by publicly funded health insurance programs. The cost effectiveness of adequate treatment, the moral mandate to address these significant health conditions -- as well as the cost returns to society of effective treatment in reduced medical expense, reduced employee absenteeism, reduced incarceration, reduced child protection needs and reduced highway mortality -- suggest that full parity in coverage should be legislated or created by rule.

The ASAM Public Policy Statement addressing the “Core Benefit for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence” states that insurance plans should cover all levels of care that are determined to be medically necessary under established utilization management criteria such as the ASAM Patient Placement Criteria. Over 15 years since this statement was adopted by ASAM, the principles in it still apply: Level I (general outpatient care), Level II (intensive outpatient or partial hospitalization care), Level III (non-hospital based residential care of varying intensities/durations) and Level IV care (hospital based intervention, treatment, and consultative services) for addiction evaluation and management and for intoxication/withdrawal and management -- including opioid

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*Public Policy Statement on Core Benefit for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence, April 1993.*
maintenance treatment and other modalities of “medication-assisted treatment” -- should be covered, when medically necessary, by Medicare, Medicaid, TriCare, CHAMP-VA, the Indian Health Service, and other government-funded health insurance plans and systems of care.

RECOMMENDATIONS:

1. Parity (between addiction medicine and psychiatric care on the one hand and general medical services on the other hand) should exist in government-funded health insurance plans and systems of care.

2. Federal regulations and administrative rules should specify that the parity provisions outlined in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 should apply to managed Medicare (“Medicare Choice”) plans.

3. Access to all medically necessary levels of care should be available to persons whose health care services are paid for by government-funded insurance plans and systems of care.

4. In order to assure access to medically necessary non-hospital-based acute care and extended care residential services to treat addiction, the Medicaid-based Institute for Mental Disease (IMD) Exclusion should be repealed.

5. Pharmacy Benefit Management (PBM) plans under Medicare, Medicaid, TriCare and CHAMP-VA should use prior authorization processes for addiction management, withdrawal management, overdose management, and management of psychiatric disorders which are structured on a par with prior authorization processes for pharmacotherapies for general medical conditions.

6. FDA-approved pharmacotherapies for addiction, withdrawal and intoxication management should be included in formularies for government-funded health insurance plans. Methadone maintenance therapy, sublingual buprenorphine therapy, nicotine replacement therapy, and other pharmacotherapies for nicotine dependence and alcohol dependence should be allowable as treatment options when medically necessary, and should not be categorically excluded as treatment options for persons covered under government-funded health insurance plans.

7. Fee structures under Medicare, Medicaid and TriCare should not be set so low as to discourage provider participation in federal insurance programs.
8. Provider networks should not be so restrictive that patients have too few geographically accessible options to care for their substance related disorder, or so exclusionary that care by an appropriately knowledgeable physician and system of care is not reasonably available.

9. Addiction Medicine physicians should experience parity when they seek membership in provider panels for government-insured health plans or systems of care. Certification in Addiction Medicine by the American Society of Addiction Medicine, the American Board of Addiction Medicine, or the American Osteopathic Academy of Addiction Medicine should be considered sufficient grounds for inclusion in provider panels for the treatment of Substance Related Disorders.

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